

THE HISTORY AND DEVELOPMENT OF LOCAL MEDICAL COMMITTEES,  
THEIR CONFERENCE AND ITS EXECUTIVE.  
(VOLUME 2.)

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M.D. UNIVERSITY OF EDINBURGH 1974.



THE CHARTER CRISISA change of Government and an Incomes Policy

Following the defeat of the Conservative Government and the election of a Labour one, a statement of intent on productivity, prices and incomes was agreed between the trade unions and representatives of the employers. A copy accompanied by a letter from Mr. A.W. France, Permanent Secretary to the Ministry of Health, was sent to the B.M.A., the chairmen of the J.C.C. and the G.M.S.C. Mr. France pointed out that it had not been possible to consult all interests but further discussions would take place in due course on the application which the arrangements might have to the remuneration of Health Service staffs. Dr. Stevenson expressed the profession's full confidence in the independent Review Body procedure. He assumed that the Government would accept and act promptly upon any recommendations which the independent Review Body might make<sup>671</sup>.

Mr. Kenneth Robinson, the new Minister of Health, sent a letter to each family doctor in the National Health Service in England and Wales in which he referred to the steps which had been taken to solve some of the current problems. He made a brief "statement of intentions for general practice"; proper remuneration based on the advice of the Review Body; a fairer system of meeting practice expenses; more group practice and more ancillary staff; better opportunities for keeping up to date; better premises wherever they were needed; and, in the longer term, more doctors and the deployment of medical manpower to the



best advantage within a pattern of medical care in which the family doctor must be the central figure<sup>672</sup>.

#### The Review Body's Fifth Report

The Council of the B.M.A. issued a statement to the chairmen and honorary secretaries of all branches and divisions that it was satisfied that the Review Body was dealing with the complex and important matter with all possible speed and that the report to the Prime Minister would not be long delayed. The Council was reminding the Government again that the situation in general practice was so critical that a speedy announcement of the Review Body's findings and of the Government's intention to implement them was of paramount importance<sup>673</sup>.

Dr. Cameron gave the G.M.S.C. a brief summary of the conflicts between the medical profession and the State as an employer. In certain areas of the country doctors were banding together and calling for violent action, sanctions and threats of sanctions against the Government. Whilst the G.M.S.C. sympathised with them it was their responsibility to lead the profession wisely at such a critical point in the history of the National Health Service and the profession of Medicine.

The Chairman then sought the Committee's guidance as to the attitude it should take towards the M.P.U. which had circularised to general practitioners a scheme for partial withdrawal from the National Health Service that had received considerable publicity in the national press<sup>674</sup>. Dr. Arnold Elliot, on behalf of the

M.P.U., said that at the Union's annual meeting in November many members were militant because many of the best doctors were leaving the National Health Service and emigrating. Unless urgent action were taken the Union doubted whether the family doctor service would be able to continue, and his council had been instructed to find out the attitude of the doctors. The scheme outlined was only one of several possibilities. The Committee passed a resolution expressing its confidence in the independence of the Review Body and deprecating any precipitate action, "including the action of the Medical Practitioners' Union in the Crisis Newsletter dated January 16 1965"<sup>675</sup>.

The third, fourth and fifth reports of the Review Body were presented to the Prime Minister in January and after being accepted by him they were published in February<sup>676</sup>. The Review Body recommended that the pool should be increased by £5½m, a large part of which should be used to make possible the introduction of the proposed scheme for the partial direct reimbursement of the cost of ancillary help and maintaining practice premises. This would, in effect, reduce the £5½m to between £1½m and £1¼m. In a letter to every doctor, Dr. Stevenson, the Secretary of the B.M.A., set out the facts. He said that the G.M.S.C. and the Council were to meet; meanwhile their Chairmen had instructed him to say that in their view the award was a failure on the part of the Review Body to appreciate fully the gravity of the crisis in general practice<sup>677</sup>.

A copy of the Review Body's Report was sent to each general practitioner by the G.M.S.C. with a copy of GMS Voice No. 4.

# The G.M.S. Voice

Issued by the GENERAL MEDICAL SERVICES COMMITTEE for Family Doctors practising in the National Health Service.

## THE REVIEW BODY REPORTS

### THE REPORT EXAMINED

#### The method of remuneration

**WE** PROPOSED THAT "the earnings of general practitioners from the Pool should be assessed solely in relation to general medical services provided to patients on their lists". In other words, that the Pool should be used mainly to distribute fees in the form of capitations and loadings.

The Review Body advocates a Pool based on all the payments made by Executive Councils and excludes only those payments for work done for hospitals, local authorities and Government departments. Thus, the Pool will continue to include not only payments for general medical services but for maternity, sight testing and dispensing.

This concedes the principle but goes only part of the way. It does not guarantee stability to the capitation fee. Capitation fees will still be subject to fluctuation because these other Executive Council payments are liable to alter because of circumstances over which there is no control. For instance, if the birth rate rises, or if more domiciliary midwifery is undertaken by general practitioners, then the total payments for general medical services will still fall, despite the fact that the doctor's work has increased.

#### Same yardstick

Although the Pool is to be based on Executive Council payments alone it is the Review Body's intention that total income from all official sources will still be used as a yardstick in making comparisons with the incomes of other professions at future triennial reviews.

What does this mean?

In the past, family doctors have hesitated to do hospital work, for instance, because of the effect on the Pool, and thus on their own — and their colleagues' — pay for general medical services. Once these payments are taken out of the Pool, those who have the opportunity, the wish and the time will feel encouraged to do more work in hospitals. Initially this will have no effect on remuneration for general medical services. But when comparison is made between doctors' incomes from all official sources, and the incomes of other professions, the effect of an increase in payments from outside sources including hospitals, will again be taken into account. As a result, this could seriously affect any increase in pay for general medical services due on economic grounds. The same applies to extra work for Government departments and local authorities. The whole system remains illogical.

#### Retrospection

Because the Government delayed setting up the Review Body until late in the first three-year period, speed was essential and the first claim (made in 1962) had to be upon purely economic grounds. But it was made clear at the time that a review of the structure of

### FROM THE CHAIRMAN OF THE GENERAL MEDICAL SERVICES COMMITTEE

**I** AM SENDING you with this issue a copy of the Report on the Remuneration of General Medical Practitioners which the Review Body has sent to the Prime Minister and which the Government has announced it accepts in full.

The Report, a detailed and complex document, merits the most careful attention. In this issue of the *G.M.S. Voice* the aim is to explain the Report and its full implications. It poses the question which every family doctor must ask himself: Can I in the best interests of my patients and my profession continue to offer my professional services through the medium of the National Health Service as long as the Pool system remains the basis of remuneration?

You will already have had a letter from the Secretary of the British Medical Association informing you that the Joint Evidence Committee of the medical profession regard this Report as a most disappointing outcome to the claim. In the same letter the Chairman of the B.M.A. Council and I gave our immediate reactions.

There are to be emergency meetings of the General Medical Services Committee on February 11th and of the Council on February 17th. Immediately after this the advice of these bodies will be sent to you. In the meantime I want you to make yourself familiar with all the facts and their possible implications, so that you will be in a position to form your own judgement and to appreciate the full significance of any decisions you may be asked to take.

The Review Body was made aware of every single aspect of the general practitioners' case, which had the approval of the entire profession. They have completed their task within the limitations imposed by their terms of reference. But in my judgement they have produced a report which hardly begins to meet the critical situation in general practice. I know you will all share my disappointment and my resolution to continue to fight for the fundamental changes in pay structure and terms and conditions of service, which general practice urgently needs. We must remain united in order to achieve a satisfactory family doctor service.

remuneration in general practice was regarded by the profession as an essential part of that first review. The Review Body accepted this contention — and the reasons for it. They agreed to consider further evidence as soon as it could be produced. In the circumstances it is difficult to understand why the Review Body, having now accepted that further improvements were, in fact, necessary, now refuse to apply their own remedy retrospectively to April 1963. The new award should have been regarded as an integral part of the 1963 review.

#### The amount of remuneration

Leaving aside for the moment the £5 million for seniority payments, our claim was for an extra £13 million for general medical services alone, so that the doctor providing only these services would be guaranteed on average, a net income of £2,765 per annum. This award is estimated to produce about £5½ million. It proposes that the net income should be guaranteed at £2,775 for all Executive Council services — not for general medical services only. To add the pay for the other Executive

Council work will undermine the stability of payments for general medical services. Included in the total sum of £5½ million there is a small sum, averaging £10 per annum per doctor which comes to £½ million. This, seemingly, is in recognition of his increased work.

In paragraph 57 of the report it is suggested that the overall effect of the proposals would be to secure an average net annual income from all official sources (the previous yardstick) of over £3,000. But it must be realised that this consists of the new guaranteed net income of £2,775 from Executive Council sources, together with, on present official estimates, about £240 per annum from sources other than Executive Councils.

This figure of £240 is by no means a stable one and the hypothetical figure of £3,000 may never be achieved. Earnings from these outside sources have fluctuated in the past and they will do so again. To judge from recent figures, the trend might easily be downwards. At a time of economic crisis, this trend could well be accelerated as a result of Government action. Indeed, because of the need to care for

an ever-increasing number of patients, the doctor may find that he cannot undertake this outside work at all.

### Only £2,775 guaranteed

So, although it may be the intention of the Review Body to provide an average annual income from all official sources of £3,000, they have done nothing to guarantee an income above the £2,775 level. On the other hand in paragraph 42 the Review Body makes it plain that if the income from non-Executive Council sources should rise, then this rise will again be taken into account. Therefore any future claim for an increase in the income from Executive Councils (justifiable on general economic grounds) could still be offset by a rise in income from other sources. If the Review Body's aim is an average income of £3,000 they might be prepared at some future review to add to the £2,775 if there should be an unexpected fall in income from all other sources. But there is no evidence that this is what will happen.

### Limiting conditions

The capitation fee would only go up by about 2s. even if the whole £5½ million were devoted to this purpose. But the Review Body has stipulated that "the additional money which this recommendation would make available in the pool should be drawn upon so far as necessary to make possible the introduction of schemes for the partial direct reimbursement of expenditure on ancillary help and practice premises". The Review Body has estimated that about three-quarters of the £5½ million will be needed for this primary purpose, leaving only enough for about 6d. on the capitation fee. In other words the family doctor at best receives an increase of 1d. per consultation.

The decision by the Review Body to impose such limitations upon the distribution of the award is contrary to the undertaking given by Mr. Anthony Barber in his statement published in the Supplement of the *British Medical Journal* on 26th September, 1964. He said that it had never been his intention to impose this new method of reimbursing expenses if the profession did not like it.

**The award is truly a package deal**—£5½ million most of which can only be distributed for certain purposes and in accordance with schemes yet to be agreed. In spite of a Minister's assurances these are the conditions which are being imposed.

### 100% expenses maintained

The Ministry of Health told the Review Body that if the Pool were to be restricted to payments for general medical services, the Pool should be credited only with the corresponding expenses. With the arrangements now proposed this would have meant that the expenses incurred in work for hospitals, Government departments and local authorities and even on private practice, would have had to be defined and excluded. The Review Body however has upheld our own view that, as in the past, all practice expenses should be credited to the Pool.

### Seniority awards—Merit awards

The second part of our claim, for some £5 million, proposed a system of awards for seniority and experience. The Review Body has not accepted this. But it has recommended that the general practitioners and the Ministry should try to devise an acceptable scheme of merit payments, based on "objective criteria". If such a scheme can be agreed, the Review Body would "if necessary be ready to recommend in order to finance it a sum substantially greater than that recommended by the Royal Commission". That sum was £1 million. No indication is given of how much money would be made available, and the scheme must hinge on this. The source of the money is not even hinted at. Furthermore if, as the Review Body suggest, "self selection" is to be possible, a fixed sum would not meet the situation, for obviously the cost would vary with the

number of doctors who complied with the conditions. Finally, if a sum of money were allocated, would this be added to the net average income from all official sources—which is to continue to be the basis of comparison with incomes of other professions?

### OTHER POINTS

#### Doctors over 70

Our proposal that the Pool should be computed on the basis of all doctors providing unrestricted services and not just those under 70, is not accepted by the Review Body.

#### Return on capital

We had asked the Review Body to advise on how the cost of capital provision in practice should be met. The Ministry's view was that the Royal Commission had taken this into account in laying down the figure of £2,425 in 1960. We did not accept this. The Review Body, believing that the Royal Commission did, in fact, make some, though unspecified, allowance for this, has recommended that the matter should be re-examined by the profession and the Ministry. We are almost back where we started.

#### Compensation

The Review Body has expressed the hope that the Government will sympathetically consider our proposal that compensation should be paid at a fixed age if the doctor has now already qualified for it.

## THE TWO SCHEMES

**WHAT IS THE STATE OF THE negotiations on the two schemes referred to by the Review Body for the more direct reimbursement of certain practice expenses?**

For over a year the General Medical Services Committee has been discussing with the Ministry of Health how to repay more directly to a doctor the expenses he incurs in his practice. They decided to examine in particular the expense of providing ancillary help, because this enables the doctor to make the best use of his time. They also examined the problem of maintaining practice premises, because the cost fluctuates greatly from one area to another.

#### Ancillary help

The scheme for more direct repayment of the cost of ancillary help has now reached a stage at which, subject to a few amendments, it can be submitted to the profession for consideration. Even so, it remains to be seen whether the profession will find it acceptable, unless the Ministry can be persuaded to make some modifications.

What is this scheme? In brief it offers immediate repayment of about two-thirds of the cost of employing an ancillary. A higher proportion would have entailed demands by the Ministry for more stringent controls which would probably not have been acceptable. The scheme is to be limited to staff engaged in nursing or treatment, secretarial work, receiving patients or making appointments, or dispensing.

There were two main problems. One was to decide the extent to which the dependents of a doctor would be eligible. The other was to determine the best way to start the scheme without prejudice to the capitation fee—because the scheme represents a re-distribution of gross fees, and at first some doctors would do better than others.

#### The doctor's wife

The proposal is that doctors' dependents should only be included if they work full-time in the practice. But the definition of 'full-time' has still to be finally decided. The Ministry had also proposed that for approximately two years, the cost of starting the operation should be met by over-payment from the Pool (letting the Pool go 'into the red') in order to protect the capitation fee. This excess payment would be met out of any

increase in net remuneration during that period. In fact this was a mortgaging process which the Review Body knew would probably be unacceptable to the profession. It is therefore all the more surprising that the Review Body has seen fit to impose just such a condition in its own "package deal". It is also possible that the proposals for doctors' dependents in the scheme will not be acceptable.

#### Practice premises

As for the cost of practice premises, the problem seems to be the direct repayment of the excess where the cost is above-average, especially rent, rates or servicing capital. What is the average is difficult to establish, and a large scale survey is about to be started. But it is unlikely that its results, and agreement on a scheme, will be reached for some time.

Thus with a scheme for ancillary help not yet accepted, and a premises scheme still at the embryo stage, one wonders what is to happen to three-quarters of the award earmarked for these purposes during the first year or so. Will the money be permanently reserved until some scheme is working? Or will any sum reserved be paid out each year as a final settlement until the schemes can begin to operate?

Furthermore, these two tentative schemes are only two aspects of practice expenses which have so far been considered suitable for more direct reimbursement. There are other aspects to worry the individual doctor.

#### Not relevant

So far as the method of financing these schemes goes, it must be made plain that at no time during the discussions with the Review Body were the profession's representatives led to believe that these schemes were relevant to our claim. Their only relevance as far as the Joint Evidence Committee were concerned, was to illustrate the financial difficulties in general practice and the anomalies of the Pool system.

**THIS ISSUE** of the *G.M.S. Voice* has been produced at short notice and at great speed. It gives you as far as possible a quick analysis of the Review Body's Report and some first reactions.

To summarise the main points:

1. Our claim to the Review Body was for a guaranteed net average income of £2,765 for general medical services alone. We have been given a modified Pool system, which still includes maternity and dispensing. The capitation fee can still fluctuate. Total income from all official sources is still the yardstick.
2. The award itself amounts to £5½ million against the claim of £13 million which we made for general medical services.
3. Our claim for £5 million for additional payments for seniority and experience has been rejected.
4. The major part of the £5½ million we have been awarded for net income is to be set aside to finance two schemes for the direct reimbursement of practice expenses.
5. The capitation fee is likely to go up by only 6d.

The next steps are:

There will be a thorough examination of the Review Body's Report by the General Medical Services Committee on Thursday, February 11.

The B.M.A. Council will meet for the same purpose on Wednesday, February 17.

These two bodies will decide what action is possible and what to advise.

We shall keep you informed through another issue of the *G.M.S. Voice* very soon.



This outlined the main points of the Report and included a letter from the Chairman of the G.M.S.C. asking doctors to familiarise themselves with the facts and the possible implications<sup>678</sup>.

The G.M.S.C. met on February 11 and issued a statement:-

"The General Medical Services Committee, fully conscious of its responsibilities to the community and the profession to provide the best possible general medical service, is profoundly disappointed with the award of the Review Body. This, taken in conjunction with the award made in 1963, demonstrates beyond all doubt the impossibility of ever securing justice for family doctors so long as the present Pool system remains the basis of remuneration.

The G.M.S. Committee recommends the Council to inform the profession at once of this view, and to instruct the profession's representatives to initiate immediate discussions with the Ministry with a view to devising an entirely new contract of service.

The Committee emphasizes that a necessary preliminary to such negotiations must be an undertaking by the Minister that he will adhere to the assurance given in his letter (Supplement 9 January, p.9) and that of his predecessor in his statement published in the B.M.J. (Supplement, September 26, 1964, p.165) - i.e., that no scheme of more direct reimbursement of practice expenses would be imposed on the profession if it were not their wish - by immediately and unconditionally crediting to the Pool as an interim measure the £5½m awarded by the Review Body for distribution

to general practitioners as net remuneration in the form of capitation fees.

In the meantime the Council is recommended, through the British Medical Guild, to advise family doctors to exercise their prerogative to terminate their contract of service with the N.H.S. after the statutory period of three months' notice has been given. The British Medical Guild will issue immediate instructions on the precise timing."<sup>679</sup>

This information was released to the Press and given to the entire profession in a further letter from the Secretary of the Association<sup>680</sup>.

The Central Consultants and Specialists Committee issued a statement supporting the general practitioners<sup>681</sup>. Council endorsed the G.M.S.C.'s recommendations and submitted a four point "charter" to the British Medical Guild. This insisted that the doctor should have the right to practise good medicine in company with doctors from other branches of the profession from suitable up to date and convenient accommodation, the right to practise medicine to the best of his ability with the least possible intrusion by the State, the right to a proper payment for services tendered, and the right to financial security after retirement for himself and his dependants<sup>682</sup>. This four point charter was incorporated in a report sent by the British Medical Guild to all doctors in contract with Executive Councils, inviting them to submit their resignations<sup>683</sup>.

Replying to a debate in the House of Commons on the evening of February 17 the Minister of Health said that Ministers of the Crown could not make the first approach in such a situation<sup>684</sup>. The following morning Dr. Stevenson wrote to the Minister that it would be folly to stand on ceremony and that the profession was willing to treat the Minister's statement as an invitation. The Minister replied immediately that he would be glad to see representatives of the profession as soon as possible and on the 19th Mr. Robinson, together with the Permanent Secretary, Mr. Arnold France, and the Chief Medical Officer, Sir George Godber, met Mr. Nicholson-Lailey, Dr. J.C. Cameron, Dr. Stevenson and Dr. Hedgecock, Secretary of the G.M.S.C. After five hours of discussion it was agreed that the Review Body should be asked for clarification of certain parts of its Report. In essence this meant that it would be asked to say what would be the effect on its award of £5<sup>1</sup>/<sub>2</sub>m if the profession was unable to agree to the expenses scheme<sup>685</sup>.

#### A Charter for the Family Doctor Service

On February 23 the G.M.S.C. realised that the major issue was not money but the terms and conditions of service. It elected a small drafting committee consisting of Drs. J.C. Cameron, I.M. Jones, E.V. Kuenssberg, A.M. Maiden, D.P. Stevenson and W. Hedgecock to draw up a manifesto setting out the basic principles of a new contract for general practitioners<sup>686</sup>.

The drafting committee spent an entire weekend working on its memorandum which was approved by the G.M.S.C. on March 4 and by

the Council on the 5th. It was then published as "A Charter for the Family Doctor Service"<sup>687</sup> and sent to every practitioner.

On March 12 Drs. Hedgecock and Stevenson sent a further letter to all doctors, informing them that they were in daily discussion with the Minister of Health and hoped to receive his reply to the Charter proposals on Monday evening, March 15. They noted that 15,302 resignations had been received by the British Medical Guild up to the morning of March 12<sup>688</sup>.

At a meeting between Mr. Robinson and Dr. Cameron and their advisers it was agreed that the £5 $\frac{1}{2}$ m increase in remuneration should be added unconditionally to the pool and be distributed by increasing both the capitation fee of 20/6d. and the temporary resident's fee of 21/- to 22/6d. with effect from April 1 1965.\* The Minister wrote a letter to Dr. Cameron recording this agreement. He was prepared to accept the Charter as a basis for discussion on a new contract, providing that the quantum of remuneration should continue to be set by the Review Body<sup>689</sup>.

A letter signed by the Chairmen of the Council and the G.M.S.C. which summarised the past events and informed the profession that

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\* An agreed estimate of the implied increase of doctors' incomes which had been prepared jointly by the expert advisers to the Minister and the profession showed that an increase of £40 $\frac{1}{2}$ m would be necessary in the remuneration for 1965/6 if the Charter proposals were implemented from April 1 1965<sup>690</sup>.



Secretary: DEREK STEVENSON, I.D., M.R.C.S., L.R.C.P.

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## British Medical Association

BRITISH MEDICAL ASSOCIATION HOUSE  
TAVISTOCK SQUARE  
LONDON, W.C.1

PLEASE ADDRESS ALL  
COMMUNICATIONS TO THE SECRETARY  
AND QUOTE REFERENCE

12th March, 1965.

Dear Doctor,

We last wrote to you on Monday of this week sending a copy of our Charter for the Family Doctor Service.

Since then your representatives have been in daily discussions with the Minister of Health and we are writing to let you know that we expect to receive the Minister's answer to our proposals on Monday evening, March 15th. There will be special meetings of the General Medical Services Committee on Tuesday, March 16th and the Council on Wednesday, March 17th.

We shall, therefore, be in a position to let you have, by next weekend, the full facts and the recommendations which the G.M.S. Committee and the Council will be making to the Joint Meeting of the Conference of Local Medical Committees and the Representative Body on March 24th.

Secretaries of Local Medical Committees and of Divisions of the Association have been asked to convene local meetings in the days immediately preceding the Joint Meeting. Please make every effort to attend your local meeting.

Resignations - this morning 15,302 - are still coming in steadily to the British Medical Guild, and with them have been many enquiries about alternative schemes. Details of a private insurance scheme will appear in next week's British Medical Journal, and the next issue of the G.M.S. Voice.

Yours sincerely,

16,703 resignations had been received was sent to all doctors. The letter formed the basis of the report which was to be submitted to the joint conference of the Representative Body and the Conference of Local Medical Committees which had been convened for March 24. In the G.M.S.C.'s view the progress that had been made was not sufficient to justify the British Medical Guild's returning the undated resignations which it held, but because of the Minister's letter more time should be allowed to test the Government's intentions. Whilst appreciating that some of the proposals involved amending legislation and that it would take some time to effect a new contract, the Committee was convinced that a much shorter time could be set to test the Government's intent on a limited number of the profession's proposals. This would serve as an indication of the Government's probable attitude to the remainder. The Committee therefore recommended that the Guild be advised to hold the resignations for a further period of three months, that is until June 30 1965, and that in that period the Ministry be asked to give positive and unequivocal assurances on certain matters. These included a firm promise that early legislation would be introduced to finance the provision and improvement of practice premises and, to relieve the pressure on the doctors, the Minister would make additional money available for the employment of ancillary help on terms satisfactory to the profession. The Government would also have to agree to reduce the burden of certification. If the pricing of the contract was to be referred to the Review Body it must be on terms which ensured that the pool was abolished, that the assessment of professional remuneration should be "ab initio", and that the

basis could be applied to alternative forms of remuneration such as capitation fee, item of service or some form of salary.

Furthermore, the reference to the Review Body should neither be restricted by the criteria established by the Royal Commission nor prejudiced by the conditions expressed in Paragraphs 42 and 46 of the Review Body's Report. Unless these assurances were received the Committee\* could see no option but to advise the Guild to submit the resignations on July 1.<sup>691</sup>

Accompanying the letter was a copy of the letter from Mr. Kenneth Robinson to Dr. Cameron referred to above. The Minister's reply and the G.M.S.C.'s recommendations were also sent to all family practitioners in an issue of GMS Voice; the pamphlet contained a rough outline of a B.M.A. insurance scheme which would be implemented in the event of mass resignations<sup>694</sup>.

#### Special Meetings of the Representative Body and the Conference of Representatives of Local Medical Committees

The Representative Body of the B.M.A. and the Conference of Representatives of Local Medical Committees met together at 10 a.m. on March 24 1965 in the Great Hall of BMA House, London. The Conference was formally opened by its Chairman Dr. Maiden and the

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\* The Council approved the G.M.S.C.'s action at its meeting of March 17<sup>692</sup>. The word "committee" in Dr. Cameron's letter was replaced by "Association" in the report to the Joint Conference as printed in the British Medical Journal<sup>693</sup>.

Chairman of the Representative Body Dr. Ronald Gibson opened the Representative Meeting. The two bodies thereafter combined under the joint chairmanship of Drs. Gibson and Maiden for a joint debate on the recommendations of the G.M.S.C. and the Council outlined above<sup>695</sup>.

In his opening speech to the joint meeting Dr. Cameron reported that 17,241 resignations had been sent to BMA House. As the profession was involved in collective bargaining it was essential that its solidarity be maintained. The meeting had a simple issue to decide; whether the Guild should send in the resignations it held on April 1 to take effect from July 1 or not. A general debate took place on the subject but no motions or amendments were put to the combined meeting, which terminated at lunch time<sup>696</sup>.

A Special Conference of Representatives of Local Medical Committees was held at 2 p.m. to consider the G.M.S.C.'s recommendations<sup>697</sup> and when it had finished at 4.30 p.m. a Special Representative Meeting considered identical recommendations from the Council<sup>698</sup>. Both meetings agreed that the Guild should be advised to hold the resignations in its hands for a further period of three months, i.e. until June 30 1965 to await the Minister's positive and unequivocal assurances on the "testing points".

#### Conflicting decisions of the G.M.S.C. and Council

Sir Geoffrey Lawrence Q.C., was retained by the G.M.S.C. to advise on the negotiations on the new contract and Dr. D.T. Jack was engaged as an additional expert adviser to the negotiating

team.\* The Committee reaffirmed the appointment of Drs. Cameron, Jones, Kuenssberg, Maiden, Stevenson and Hedgecock as its negotiators with the Minister, and Dr. Cameron reported that they would be meeting the Minister every Wednesday and Thursday over the coming weeks. The Committee also appointed working groups on certification, disciplinary machinery, the proposed independent corporation for practice premises, and another on inducement payments to encourage doctors to practise in under-doctored and special areas. These working groups were to provide assistance in the preparation of the negotiators' case<sup>699</sup>.

The G.M.S.C. met on May 27 to consider a joint report of the discussions between the Minister and the representatives of the profession upon the Charter for the Family Doctor Service<sup>700</sup>. The Committee also considered a letter from the Review Body which revealed that it would not object to the profession's evidence being published, provided that it was not published before the Review Body itself had received it. Furthermore, the Review Body would not object to the Health Departments' written evidence being published, again provided that it was not published before the Review Body had received it. However, the

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\* Sir Geoffrey had been one of the seven members of the Review Body until he resigned in 1962 on being appointed Chairman of the National Incomes Committee. Dr. Jack had been Chairman of the Railway Staffs National Tribunal since 1963 and Professor of Economics at the University of Durham from 1935 to 1961.

oral evidence of both the Joint Evidence Committee and the Health Departments would remain private but the Review Body would not object if, for the next review of general practitioner remuneration, the Joint Evidence Committee gave oral evidence with Counsel as their chief spokesman<sup>701</sup>.

The Committee recommended to the Annual Conference of Local Medical Committees that the negotiations on the Charter as a whole should continue, that the existing undated resignations held by the British Medical Guild should be destroyed, and that the proposed scheme for the more direct reimbursement of the cost of ancillary help should be implemented from October 1 1965<sup>702</sup>.

The Council met the following day and gave careful consideration to the G.M.S.C.'s recommendation that the existing undated resignations held by the British Medical Guild should be destroyed. Although Council had complete confidence in the profession's representatives and congratulated them on the progress they had made, it considered that progress would not have been possible without the overwhelming support of the profession and that to retain the undated resignations would strengthen the hand of the profession's representatives. The Council therefore recommended to the Special Representative Meeting (due to be held on June 23) that the undated resignations should continue to be held by the British Medical Guild, that the negotiations on the Charter as a whole should continue, and that the profession's representatives be authorised to seek the implementation of the proposed scheme for the more direct reimbursement of doctors' ancillary help from October 1965<sup>703</sup>.

After the meetings of the Council and the G.M.S.C. meetings were called by Local Medical Committees all over the country to consider the G.M.S.C.'s report. For example, on June 4 1965 at the Faulkner Hall, St. Albans, Hertfordshire, 79 of the 356 doctors registered in Hertfordshire attended a meeting convened by the Hertfordshire Local Medical Committee. They heard Dr. C.M. Scott, their representative on the G.M.S.C., recommending that the resignations be destroyed and Dr. J.G.R. Clark, a member of the Council, recommending they be retained. Dr. D.L. Gullick, under-secretary of the B.M.A., emphasized that both the G.M.S.C. and the Council were satisfied that the requirements set by the Special Conference had been met and that the Minister had given evidence of good faith and that the question of the resignations was therefore a lesser point. Twenty doctors took part in the discussions and a motion that the resignations should be submitted on June 30 was heavily defeated. The meeting agreed with the Council that the resignations held by the British Medical Guild should be retained until further notice and that the profession's representatives be authorised to seek the implementation of the proposed scheme for the more direct reimbursement of the cost of ancillary help. The report of this meeting was considered by the Hertfordshire Local Medical Committee at its meeting on June 9 1965 and endorsed for submission to the Annual Conference of Local Medical Committees<sup>704</sup>.

#### The Annual Conference of Representatives of Local Medical Committees of June 1965

The main business of the Conference was to consider the report and recommendations of the G.M.S.C. on the remuneration and terms



and conditions of service of general practitioners. The first part of an amendment by Doncaster "that the report of the General Medical Services Committee on remuneration and terms and conditions of service of general practitioners does not contain the positive and unequivocal assurances which were sought at the Conference on March 24 1965", was rejected by 113 votes to 98, and the second part of the amendment "that the undated resignations be submitted on the 1st July 1965", was rejected by 160 votes to 41. The Conference then carried by a large majority an amendment by Staffordshire "that this Conference is of the opinion that the existing undated resignations held by the British Medical Guild should be retained until such time as the new Charter has been negotiated and the contract priced". An amendment in the name of Lothian and Peebles "that the proposed scheme for the more direct reimbursement of the cost of ancillary help be not implemented until the implementation of the Charter a whole" was carried.

The Conference also agreed by 101 votes to 77 that the members of the G.M.S.C. and its related sub-committees should be adequately recompensed for the time that they spent on behalf of the profession generally by working on these bodies. The honoraria should be paid out of the Defence Trusts<sup>705</sup>.

A Special Representative Meeting on June 23 also decided that the resignations should be held by the Guild until a final settlement had been reached between the Minister and the profession but expressed dissatisfaction with the assurances given in the joint



report. In view of the decision of the Conference the Chairman of the Council requested that the Council's recommendation on the proposed scheme for the direct reimbursement of the cost of ancillary staff should be withdrawn. The meeting agreed to this action<sup>706</sup>.

#### The Annual Representative Meeting at Swansea

A minor medico-political crisis occurred when the Annual Representative Meeting at Swansea resolved that payment by the patients of fees for items of service, in part or wholly recoverable from the State, should be included in the Charter as one method of remuneration. The Times claimed that the general practitioners were prepared to resign on this issue<sup>707</sup>, although a hastily convened Council meeting had decided that the motion was not a resignation issue<sup>708</sup>.

The Minister issued a statement that the new proposal, that fees should be paid by National Health Service patients, was quite

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\* In a leading article The Times pointed out that the doctors' leaders' task was made more difficult by the frequent changes of policy made by the members of the Association<sup>709</sup>, and 50 Labour Members of Parliament protested against the Representative Body's decision<sup>710</sup>. Laurence Pavitt M.P., speaking at a meeting of the Confederation of Health Service Employees, claimed that the doctors were losing the goodwill that they had had at the onset of the dispute<sup>711</sup>.

unacceptable to the Government although it was aware of the difficulties of the practitioners, including their work load, and was anxious to negotiate on the Charter. The B.M.A. replied that the Minister's statement created a "serious situation" and asked what alternatives the Minister had to relieve the burden of family doctors<sup>712</sup>.

Mr. Nicholson-Lailey and Dr. Cameron wrote to all general practitioners explaining the implications of these developments. They pointed out that amongst all the differing shades of opinion expressed at the recent Conference, two things had stood out quite clearly. Firstly the profession wished to see the Charter as a whole negotiated before making its final decision on the future of the Service and secondly immediate steps must be taken to contain the demand on family doctors at a time when there were too few of them to care for a steadily increasing population. They undertook to keep general practitioners fully informed of any developments but meanwhile negotiations on the Charter were continuing<sup>713</sup>.

#### The Second Report of Joint Discussions

On October 6 1965 the Second Report of Joint Discussions was published<sup>714</sup>. It recommended that a basic practice allowance should be paid to all doctors who satisfied certain conditions. In addition to the standard capitation fee there should be extra payments for patients who were elderly, standby payments for services at night and weekends, a supplementary capitation fee to cover out of hours responsibility for patients on the doctor's

list in excess of 1000 and a uniform fee for visits requested and made between midnight and 7 a.m. Additions to the basic practice allowance for seniority, experience and special qualifications, practising as part of a group and service in unattractive areas were suggested. It envisaged a postgraduate training allowance and fees for certain items of service carried out in pursuance of public policy, such as cervical smears, vaccinations and immunisations. Fees for maternity medical services, temporary residents' fees, emergency fees and rural practice payments and dispensing fees would continue. In addition there should be direct repayments, in accordance with agreed schemes, of expenditure on ancillary staff, rent and rates, and locum and other deputies necessarily employed during the practitioner's own sickness. Salaried contracts would be offered to a selected group of doctors who preferred this method of payment as soon as conditions for a salaried service could be worked out. The Government expressed the view that it was neither feasible nor desirable for there to be payment by "fees for item of service" for the general run of the doctor's work but it was willing to consider with the profession whether mutually accepted safeguards could be devised for a limited experiment.\*

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\* Neither the item of service nor salaried methods of payment were introduced, as agreement between the two parties could not be reached.

The concluding paragraph of the Report reiterated the Government's view that only the Review Body could recommend levels of remuneration and its agreement with the views of the representatives of the profession that the Review Body should be invited to price at least the major items in the modified capitation system separately. Since the fees would be gross, it would be necessary to ensure that they made proper allowance for practice expenses.

The G.M.S.C. at its meeting on October 12 considered the Second Report, and whilst sharing the regret of the profession's representatives that the Government's offer did not provide the full flexibility of payments envisaged by the Charter, it nevertheless took the view that by its declaration that the excessive work load should be taken into account with other factors in fixing the level of remuneration and its agreement to the abolition of the pool, the Government had shown a willingness to meet the other essential requirements in the Charter. The Committee recommended that the form of the proposals for a new pay structure were of such a nature that they could go forward to the Review Body for pricing; approval of the recommendation should be sought by means of a postal ballot amongst general practitioners within the National Health Service<sup>715</sup>.

The ballot was supervised by Messrs. Price Waterhouse, Accountants to the B.M.A. and 24,255 ballot forms were issued. By the closing time, 12 noon on Monday, November 1 1965, 17,602 replies had been received agreeing with the proposal that the recommendations in the Second Report should be sent to the Review Body for pricing,

and 2660 disagreeing. There were 300 spoilt or incomplete returns<sup>716</sup>.

### The Seventh Report

The Review Body decided that because its 1963 recommendations as modified by subsequent reports could not last beyond March 1966, it would embark on a second general review and hear evidence on behalf of general practitioners separately from that of the hospital doctors.\*

Invitations were sent to the Health Departments and to the recognised representatives of the profession to submit memoranda of evidence by September 30 1965. At the same time the Review Body itself approached a number of professional institutions for information about earnings in professional practice. It also invited nearly thirty companies, covering a wide range of industry, to provide it in confidence with detailed information about earnings of staff with graduate or equivalent professional qualifications. As a result information was received relating to almost 20,000 such staff<sup>719</sup>.

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\*The B.M.A. was presenting a claim on behalf of hospital doctors but some junior hospital doctors, dissatisfied with their own representative machinery, formed a Hospital Junior Medical Staff's Action Group<sup>717</sup> which presented independent evidence to the Review Body<sup>718</sup>.

The Review Body held twenty-three meetings between October 1965 and March 1966, and heard oral evidence<sup>\*</sup> at eight of those meetings<sup>720</sup>.

Its Seventh Report, completed on March 25 1966, was published on May 4. It recommended increases in the salaries of hospital doctors ranging from 43% for juniors in their first House posts to 10% for consultants. Among the recommendations for general practitioners were a basic practice allowance of £1000 per annum, scaled down for doctors with lists of less than 1000 patients, a standard capitation fee of £1 per year and a special fee of £1.8.0. for patients over 65 years of age. For "out of hours" responsibility there would be a standby payment of £200 a year, 2/6d. per capita for every patient over 1000 and a payment of £1 for night visits. In addition there would be seniority payments and three levels, £200, £400 and £650, a vocational training payment of £125, a payment of £200 a year to those in group practices and £400 a year to those in unattractive areas. The Review Body also recommended that payments for special experience and service to general practice at a rate of £750 per year should be made to 2500 doctors and at the rate of £2500 a year to 100 doctors<sup>721</sup>.

The Government accepted the recommendations of the Review Body for hospital staffs, but because the full implementation of the

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<sup>\*</sup> The oral evidence on behalf of the B.M.A. was given by Mr. Desmond Ackner Q.C.

recommendations would increase the net annual remuneration of family doctors by some £24m as from April 1 1966, the Government was unable to satisfy itself that an immediate increase of this magnitude, coming on top of an interim increase of nearly 10% the previous year, would be justifiable in the face of the very difficult economic situation. The Government proposed to "phase" the award over two years. This would mean an increase of net income of about one sixth for the current year and a further one sixth from April 1967. The Government proposed that the merit and seniority payments recommended in the Seventh Report should be deferred for twelve months and that there should be a reduction in the combined practice allowances during the year 1966/7. Mr. Robinson expressed the hope that the profession would accept this decision and his belief that the new contract could usher in a new era for general practice in Great Britain<sup>722</sup>.

The Third Report of the Joint Discussions was published at the same time<sup>723</sup>. The G.M.S.C. sent each general practitioner a folder containing the Review Body's Report, the written evidence of the profession and the Health Departments, copies of the three reports of Joint Discussions, and a copy of Mr. Robinson's letter to Dr. Cameron. A summary of the Seventh Report and an account of the action that had been taken on "phasing", including a report of a meeting between Dr. Cameron and the Prime Minister, was included in a further issue of GMS Voice<sup>724</sup>.

A report for consideration by a Special Conference was prepared by the G.M.S.C. It deplored the phasing because the total award



## MINISTRY OF HEALTH

Alexander Fleming House, Elephant and Castle, LONDON S.E.1

Telex: 22106 Telegrams: Healthmin London S.E.1

4th May, 1966.

Dear Dr. Cameron,

I am writing to convey to you the Government's willingness to contract with family doctors for the provision of services under the N.H.S. in accordance with the proposals worked out in our discussions on the Family Doctors' Charter submitted by the representatives of the profession last year and described in the three reports of those negotiations. Two of these reports have already been published and the third is published today.

Also published today is the report of the Review Body on Doctors' and Dentists' Remuneration on the "pricing" of the new contract. Subject to the reservation on timing explained below, the Government accept the recommendations of the Review Body.

They estimate that full implementation of these recommendations would increase the net annual remuneration of family doctors by some £24m., or at least a third, as from 1st April, 1966. They have been unable to satisfy themselves that an immediate increase of this magnitude, coming on top of the interim increase of nearly 10% last year, would be justifiable in face of the present very difficult situation described by the Chancellor of the Exchequer in his Budget statement, and in the light of the Government's general policy for prices and incomes.

The Government are aware of the increased workload in general practice and the fall in the numbers of general practitioners and they accept the Review Body's conclusion that these factors justify an exceptional increase in general practitioners' remuneration. They consider, however, that the situation facing the country requires that the very large increase recommended by the Review Body should be phased over two years. This would increase net income by about one-sixth in the current year and by a further one-sixth from 1st April next, bringing remuneration up to the full amount recommended by the Review Body.

To achieve this phasing, the Government propose that merit and seniority payments should be deferred for twelve months and that the combined Practice Allowances (Basic plus Supplementary) should be paid at the rate of £1,000 a year during 1966/7. Capitation fees, including the special higher fees for older patients, would be paid at the full rates recommended and all other features of the new contract, such as direct reimbursement for rent and ancillary staff and item of service payments, would be fully implemented with effect from 1st April last, with retrospection to that date on a compounded basis where necessary. Seniority and merit payments would become payable from 1st April 1967, when the combined Practice Allowances would be increased to the full £1,200 a year recommended.

I have set out the terms of the Government's offer of remuneration for services under the new contract which they believe can usher in a new era for general practice in Britain. I hope the profession will agree that these proposals are fair and indeed, in the context of the present economic situation, generous and I look forward to learning that they are acceptable to the profession.

Yours sincerely,

(signed) Kenneth Robinson.

J. C. Cameron, Esq., T.D., M.B., Ch.B.,  
Chairman,  
General Medical Services Committee.



"was no more than adequate to resolve the crisis in general practice". However, adopting a realistic attitude it agreed that when an equitable method of phasing had been devised the Seventh Report of the Review Body, taken in conjunction with the three reports of Joint Discussions on the Charter, represented a substantial advance for general practitioners in the National Health Service. It recommended that negotiations on the Charter should continue and that the Guild should be advised to withdraw the undated resignations which it still held<sup>725</sup>.

At a further meeting the Committee accepted a modified scheme for "phasing" which had been agreed between the Government and the profession's representatives<sup>726</sup>.

A three day meeting was held on June 7 to 9 1966 at which the Annual Conference and the Special Conference to consider the Review Body's award and its phasing were held. The General Medical Services Committee's first recommendation was amended and passed in the following form:-

"That the Seventh Report of the Review Body taken in conjunction with the three reports of the Joint Discussions on the Charter for the Family Doctor Service, represent a substantial advance for general practitioners in the National Health Service, and be accepted as the basis for the negotiation of a new contract."

The Conference decided by 139 votes to 56 that it could not recommend the acceptance of payments for special experience and service in general practice; further consideration should be

given to the matter. The Conference, having deplored the Government's attitude towards the Review Body's Report, resolved that in view of the economic situation the profession should accede to the decision to phase the award, and that the method of phasing proposed in the Minister's letter of May 19 should be accepted as being as equitable as any that could be devised<sup>727</sup>.

Following the Conference decision to accept phasing, which was endorsed by a Special Representative Meeting,<sup>728</sup> the Prime Minister announced that there would be a six months' freeze of pay and prices<sup>729</sup> and a White Paper on the Government's policy on prices and incomes was issued on July 29 1966<sup>730</sup>. The B.M.A. was confused as to the effects that this would have on the pay rises that had recently been negotiated with the Government. A spokesman thought that the doctors would receive an increase backdated for four months, but that it would not be paid until December 31<sup>731</sup>. Four days later Mr. Wilson, in the presence of Mr. Kenneth Robinson, explained the effects of the standstill to the doctors' leaders in his room at the House of Commons. The doctors took the view that as the Seventh Report was partly designed to implement new items of expenditure and some doctors had already undertaken new commitments based on this assumption the Government had broken faith with the profession.

Mr. Bernard Brain, Opposition spokesman on health affairs, tabled a question in the House of Commons which made the same point<sup>732</sup>.

Mr. Kenneth Robinson wrote to the B.M.A. that whilst net incomes would remain unchanged proper allowance would be made for the higher level of expenses incurred between April 1 and September 30,

and a supplementary payment would be made at the end of the year. He confirmed that the first "phase" of the increase would be paid from October 1 1966 instead of April 1 1966 and that the money would be received by the doctors from January 1967. The effective date for those few items which had been agreed should be paid from October 1 1966 would be paid only from April 1 1967<sup>733</sup>.

Dr. Cameron gave an account of the discussions with the Prime Minister to the G.M.S.C. The profession's representatives had gained the impression that the second phase of general practitioners' remuneration would become operative from April 1 1967. After a debate, the Committee decided to recommend that family doctors, should accept the decision of the Government as responsible citizens but any exception to the standstill would justify a demand for the implementation of the Review Body's recommendations for family doctors in full<sup>734</sup>. The chairman of the Hospital Junior Staffs Group of the B.M.A., Dr. Harvey Smith, said that hospital doctors were furious and dejected<sup>735</sup>. The following day the Council asked the members of the B.M.A. to accept the "further sacrifice now demanded of the profession".

The M.P.U. considered that the failure to implement the award was a resignation issue and condemned the re-establishment of the "pool concept" for payments made during the freeze<sup>736</sup>.

#### Formation of the Junior Hospital Doctors Association (the "J.H.D.A.")

The B.M.A. asked Mr. Wilson to re-open negotiations on the question of the pay of junior doctors but it was announced that their incomes

would not be exempt from the freeze, although Mr. Robinson promised to look into the problem of those who had undertaken commitments, such as mortgages, on the expectation of a rise in pay<sup>737</sup>. Against the background of reports that junior doctors were threatening to leave hospitals<sup>738</sup> the junior members of the B.M.A. asked the J.C.C. to press for a new deal for juniors, similar to the Charter for the Family Doctor Service<sup>739</sup>. The "Action Group" which had been set up the previous year advised juniors against the militant attitude that was being advocated by some individuals, who were recommending that they should not apply for posts in hospitals. In the Group's view this would endanger the lives of patients<sup>740</sup>.

A few days later, following a meeting at the Westminster Hospital, the Action Group was disbanded. It was announced by Dr. Patrick O'Kelly of the South West Regional Group of Junior Hospital Medical Staffs of the B.M.A. that a Junior Hospital Doctors Association had been formed to press for the early implementation of the Review Body award and to improve the career structure of hospital doctors<sup>741</sup>. On September 2 Hospital Boards were authorised to give the doctors and dentists employed by them their frozen awards on December 31 and to backdate them to October 1<sup>742</sup>.

#### A break in the freeze?

On September 21 The Times claimed that 3200 shipyard workers had beaten the pay freeze. A substantial proportion of the men had received payments on the basis of an agreement signed before

the standstill date; the rest were given their rise after it.<sup>743</sup> Drs. Cameron, Stevenson and Peter Wilson met Mr. Kenneth Robinson. They claimed that this was a breach in the freeze and that they were under instructions to look for any such breach. The Minister took the contrary view. The M.P.U. announced that its representatives at the G.M.S.C. would be instructed to raise the issue and the J.H.D.A. too claimed that the shipworkers had escaped the net of the freeze<sup>744</sup>.

The G.M.S.C. supported a statement by the B.M.A. that the Government's decision to exclude the Clyde Shipyard Agreement would further unsettle the profession. It also agreed with the Departments that £800,000 should be credited to the pool as a supplementary payment for April 1 to September 30 to compensate for the increased expenses undertaken by doctors<sup>745</sup>.

#### A Charter for Hospital Doctors

The Central Consultants and Specialists Committee stated that a charter for all hospital doctors was to be drawn up immediately and that it would embody a contract for hospital junior staffs which would include such items as off duty hours, time for study, leisure and other provisions to which hospital junior staff might properly be entitled<sup>746</sup>. The Hospital Junior Staffs Group Council of the B.M.A. held a special meeting to discuss it<sup>747</sup> and the full text was published in the Supplement to the British Medical Journal<sup>748</sup>. It was submitted to the G.M.S.C. and a working party was appointed to study it and prepare a statement for consideration by the main Committee, which would then submit its comments to the Central Consultants and Specialists Committee<sup>749</sup>.

### Implementation of the Family Doctors' Charter

Regulations were laid before Parliament to implement the changes which had been agreed in the Joint Discussions and also to provide the basis on which doctors would be paid with effect from October 1 1966<sup>750</sup>. In November the Government published a further White Paper dealing with prices and incomes during the period of severe restraint, i.e. the six months to the end of June 1967<sup>751</sup>.

Mr. Robinson wrote to Dr. Cameron to tell him that the operative date for implementing phase 2 of the recommendations of the Review Body would not be affected by the White Paper. It would remain at April 1 1967 and Executive Councils had been given the necessary instructions.

Mr. Kenneth Robinson also announced the setting up of a General Practice Finance Corporation, which would operate on a commercial basis raising its funds on the market with the aid of a Treasury guarantee. Its chairman was Sir Frederick Hoare, a banker, the other members being Sir William Mullins, a former senior Government broker, Lord Crook, former chairman of the National Dock Labour Board, Sir William Murrie, former Permanent Under-Secretary of State of the Scottish Office, Mr. A.E. Orchard-Lisle, a property expert who was also vice-chairman of Guy's Hospital Board of Governors, and two general practitioners, Dr. F. Lishman and Dr. S. Wand<sup>752</sup>.

### Additional Allowance for Special Experience and Service to General Practice

A working party was set up by the G.M.S.C. on January 19 1966 to

examine the proposals for an allowance to recognise special experience and service to general practice, a further euphemism for "merit awards", set out in the Second Report of Joint Discussions, with a view to devising an acceptable scheme. This Working Party also considered the Third Report of the Joint Discussions, the Seventh Report of the Review Body and the decisions of the Special Conference and the Special Representative Meeting of 1966 that no scheme of payment could be accepted until the detailed proposals and the method of implementation were known. The Conference had also decided that the G.M.S.C. should consult all general practitioners by plebiscite before accepting any such scheme.

At a Council meeting on February 1 1967 there was considerable criticism of the G.M.S.C. because it had submitted the draft report of the Working Party to the Ministry for informal comment. The representative from Liverpool, Dr. Crawford, moved a motion of censure on the G.M.S.C. but after Dr. Cameron had explained that there had in no sense been any "negotiations" with the Ministry the entire Council with the exception of the representative from Liverpool voted against the censure motion<sup>753</sup>. On the following day the G.M.S.C. considered the Working Party's report<sup>754</sup> and the question of the timing of the plebiscite. It decided that the document should be put to the profession, with ample time for debate at local meetings. This would be followed by the Conference, with a debate on the subject, and ultimately before the scheme was finally accepted a plebiscite would be held<sup>755</sup>.



A copy of the report was sent to every general practitioner in the National Health Service accompanied by a letter from Dr. Cameron which gave the background to the problem. He pointed out that as the scheme sought to vary the Review Body's recommendations the Working Party's report had been sent informally to the Ministry of Health. The Ministry regarded the scheme as a basis for negotiations although it saw some difficulties in implementation<sup>756</sup>. Local Medical Committees were asked to arrange meetings of all general practitioners throughout the country so that their representatives to the Annual Conference of Local Medical Committees, due to be held in June, would be fully briefed of their views. Many such meetings took place; for example at an open meeting in Hertfordshire attended by 84 doctors it was decided by 80 votes to 4 to reject the principle of payments for special experience<sup>757</sup>.

The G.M.S.C. decided that it would be helpful if the Conference knew the opinion of all general practitioners on this matter and a postal enquiry was conducted by the Association's auditors, Messrs. Price Waterhouse. Each general practitioner was asked, "Are you in favour of the principle of payments for special experience and service to general practice?". Twenty-four thousand two hundred and thirty-seven enquiry forms were issued; 15,622 doctors answered "no" to the question, 4502 answered "yes" and 417 replies were incomplete or otherwise unacceptable. These results were reported in the Journal and in a letter which was sent by Dr. Cameron to the general practitioners<sup>758</sup>.



Before the Annual Conference the Inner London Local Medical Committee asked for support from other Local Medical Committees in their efforts to ensure that in any vote on the question of payments for special experience a formal division should take place<sup>759</sup>.

Item number 134 on the agenda "that this Conference rejects the principle of payments for special experience and service to general practice", was proposed by Dr. R.S. Mackenzie of Dundee Local Medical Committee. A formal division was demanded, and the motion was carried by 162 votes to 14 with one formal abstention. The record of those voting was set out in an appendix to the Minutes<sup>760</sup>.

#### The Review Body's Ninth Report

The Review Body carried out another general review of the remuneration of doctors and dentists. Its Ninth Report was published on May 7 1968<sup>761</sup>, and accepted by the Government. As far as general practitioners were concerned the award was mainly an allowance to cover the increase in the expenses element in their remuneration, with no real increase in net pay. Similarly there were only minor changes for hospital doctors. The Review Body agreed that its recommendations did little more than hold the existing remuneration position for the time being, but it would not hesitate to recommend an immediate general increase if at any time it felt this to be justified. In any case it intended keeping the position under continuous review.



# British Medical Association

B.M.A. HOUSE

TAVISTOCK SQUARE

LONDON, W.C.1

27th April, 1967.

Dear Doctor,

## PAYMENTS FOR SPECIAL EXPERIENCE AND SERVICE TO GENERAL PRACTICE

On 30th March I sent you a form on which I invited you to indicate whether or not you were in favour of the principle of payment for special experience and service to general practice.

Although in my letter I said that the results of the enquiry would be published in the *British Medical Journal* — which is still the case — I nevertheless felt that in view of the interest which this matter has aroused, every family doctor should know the result at the very first opportunity. I am, therefore, now writing to let you know that I have today been advised that the following report has been received from the Association's auditors, Price Waterhouse & Co., setting out the result of the voting.

The Secretary,  
British Medical Association,  
B.M.A. House,  
Tavistock Square, W.C.1.

Dear Sir,

### FAMILY DOCTOR SERVICE — ENQUIRY FORM RE PAYMENTS FOR SPECIAL EXPERIENCE AND SERVICE TO GENERAL PRACTICE

The General Medical Services Committee at its meeting on 16th March, 1967 decided that it would be helpful to the Conference of Representatives of Local Medical Committees to know the opinion of all general practitioners in the National Health Service on the principle of payments for special experience and service to general practice.

You asked us to supervise the enquiry on the question "Are you in favour of the principle of payments for special experience and service to general practice". Accordingly, we report that we supervised the issue of enquiry forms to, and replies received from, doctors shown by your records to be either general practitioners in the National Health Service in England, Scotland, Wales and in Northern Ireland or assistants to such practitioners.

The total number of enquiry forms issued and the replies received by us not later than Friday, 21st April, 1967 were as set out below:

	General Practitioners		Assistants	Total
	England, Scotland and Wales	Northern Ireland		
Total issued .. .. .	22,510	775	952	24,237
Replies received:				
Answering YES to question	4,203	162	137	4,502
Answering NO to question	14,881	425	316	15,622
Replies received which notified abstention from answering ques- tion or were incomplete .. ..	381	8	28	417

Yours faithfully,

PRICE WATERHOUSE & CO.

This result will be reported to the General Medical Services Committee at its next meeting, and to the Conference of Local Medical Committees at its meeting on 14th and 15th June.

Yours sincerely,

Chairman,

General Medical Services Committee.

The G.M.S.C. recommended acceptance of the specific increases as they affected general practitioners, that discussions should be started with the Review Body and the Ministry on the method of carrying out the continuous independent review, and that the matter of the loss of money due to the Government's phasing of the Seventh Report should be kept open. It also recommended that immediate negotiations should be started with the Ministry on all outstanding matters, particularly designated area payments, vocational training allowance, temporary arrangements for carrying on a practice, payment for related ancillary staffs, seniority payments and stock order forms. All possible support should be given to hospital junior medical staffs in their just claim, both in equity and in view of the potential effect on manpower and work loads in general practice<sup>762</sup>. The Conference accepted this last recommendation and resolved that in the event of the junior hospital doctors withdrawing their services, the general practitioners would not undertake their work<sup>763</sup>.

Although the Council had recommended acceptance of the Ninth Report, the Central Committee for Hospital Medical Services took the contrary view because the Report rejected all its evidence, particularly its views on the likelihood of an increase in emigration<sup>764</sup>.

Before the Representative Meeting at Eastbourne, The Times claimed that "the profession was seething with indignation and rightly so"<sup>765</sup>. However, the four hour debate showed no signs of the heat engendered in the profession; half way through the debate there was a danger

of the meeting being counted out due to the lack of a quorum. On the other hand a motion calling for direct financial contributions by patients was passed in a few minutes with scarcely any discussion. The Times considered this was "a first class example of the unpredictability of the Representative Body".<sup>766</sup>

## CHANGES IN CONSTITUTIONS

The Review Body crisis took place against the background of constitutional changes within the General Medical Services Committee and the British Medical Association.

### Changes in the General Medical Services Committee and Conference

Following the Annual Conference of 1964 a sub-committee had been appointed to look into the constitution of the G.M.S.C. On January 27 1966 the G.M.S.C. held a special meeting to consider the report of the sub-committee. This had suggested, among other things, that Local Medical Committees should be elected every three years by postal ballot. The membership of the Conference should consist of direct representatives from all Local Medical Committees on the basis of one representative for every 350 or part of 350 on the medical list of the area for whom the Executive Council was "responsible", the members of the G.M.S.C., nine nominees from the General Medical Services Committee (Scotland), six from the Rural Practices Sub-committee, three from the Assistants and Young Practitioners Sub-committee and two from the General Medical Services Committee (Northern Ireland). Only those members representing Local Medical Committees would have the power to vote. The agenda committee of the Conference should be given far wider powers and motions on minor matters submitted to it should be referred directly to the G.M.S.C. The number of members of the G.M.S.C. elected directly by Local Medical Committees should be increased to 43 from 33 and the Committee should include two direct representatives of assistants and young

practitioners. It was further recommended that the G.M.S.C. should appoint an executive sub-committee to deal with relatively minor matters. Dr. W.M.P. Winstanley produced a memorandum of dissent, in which he expressed the view that the G.M.S.C. should be smaller, but that the Conference should be larger; the Conference should continue to elect six members of the Committee but direct election from the Representative Body should be discontinued<sup>767</sup>.

The G.M.S.C. did not wish to give the Agenda Committee wider powers as this could be taken as an attempt to dictate to Local Medical Committee representatives and overrule them. It proposed that the standing orders should be amended so that the Agenda Committee would not accept motions unconnected with general practice in the National Health Service and would arrange the agenda so as to ensure time for adequate consideration of all major matters. It proposed that the direct representatives of Local Medical Committees on the G.M.S.C. should be increased from 33 to 38, and the Chairman of the G.M.S.C. (Scotland) should be an ex officio member of the parent body. These changes would produce a G.M.S.C. of 67 members. The recommendations were published as an appendix to the Committee's annual report<sup>768</sup>.

At the Conference amendments suggesting that the Committee should be autonomous and responsible only to the Conference of Local Medical Committees, that it should be nominated entirely from Local Medical Committees, that the proportion of direct representatives elected by Local Medical Committees be increased and that

the direct members be elected on a basis of universal suffrage, were all defeated. The report was approved unamended so that action could be taken to implement its recommendations<sup>769</sup>.

In 1967 the Committee reported that it had prepared revised model schemes for the constitution of Local Medical Committees which had been submitted to the Minister of Health for approval in accordance with Section 32 of the National Health Service Act 1946. When the approval had been obtained they would be circulated to Local Medical Committees<sup>770</sup>.

Unfortunately the Conference did not reach the item on its agenda which related to the suggested changes; in order that the Conference of Local Medical Committees might have a further opportunity to comment on the matter the Representative Body deferred consideration of the changes until 1968. The Conference then accepted the proposed constitution of the Conference of Local Medical Committees and the G.M.S.C. with only minor modifications<sup>771</sup>.

#### Changes in the Constitution of the British Medical Association

The Council set up a special committee in November 1963 to consider the constitution of the Association. The Council had hoped that it would be able to report to the Representative Body in 1965, but this action was delayed by the crisis in general practice and the complexity of the task facing the special committee. In 1965 the Annual Representative Meeting commented



again on certain defects in the Association's structural machinery.

During its deliberations the constitutional sub-committee took note of the views of the Representative Body and of the Chairmen of the General Medical Services, Central Consultants and Specialists, and Public Health Committees, as well as the proposals of the G.M.S.C. for a change in its own constitution. It recommended that the day to day work of the Association should remain in the hands of the two autonomous committees, the General Medical Services and the Central Consultants and Specialists. The reports of these committees would not normally be debated in detail by the Representative Body, which should discuss major items of policy only. However, to preserve the sovereignty of the Representative Body it was essential that the ordinary member, through his division, should be able to challenge the actions of one of the autonomous bodies, as indeed he could the actions of the Representative Body itself. Furthermore, since the Representative Body exercised the functions of a meeting of the shareholders of a limited company, it was a legal requirement that the Representative Body must be able to impose its will on all constituent parts of the Association. The Committee recommended that in the unlikely event of a continuing conflict the Representative Body should be assisted in reaching a final decision by a postal ballot among the members of the profession concerned<sup>772</sup>. At the Representative Meeting held in Exeter, this latter recommendation was amended so that the postal ballot could only be held by resolution of the Representative Body<sup>773</sup>.

In accordance with the wishes of the Representative Body, expressed in 1966, that future reports on changes in the constitution should be published three months prior to the receipt of resolutions for the Annual Representative Meeting, a preliminary report devoted solely to the proposed changes in the constitution of the Association was published in March 1968. It recommended that the Council be reduced to not more than 50 members, most of whom should be appointed by the Representative Body, which should itself be reduced to less than 300 members. The report also recommended that the membership of all standing committees should be appointed by the Council and should be reduced in numbers by fifty per cent. The G.M.S.C. and the Central Committee for Hospital Medical Services were specifically excluded from these recommendations<sup>774</sup>. The Annual Report of Council elaborated further on these suggested changes; it included five alternative constitutions for the Representative Body<sup>775</sup>.

One hundred and twenty-five motions and amendments concerning the proposed constitution were submitted for consideration by the Representative Meeting which was held in Eastbourne in June 1968. This Meeting resolved, inter alia, "that the constitution of the General Medical Services Committee be revised so as to increase from 33 to 38 the number of direct representatives of group Local Medical Committees; to include two representatives of the Assistants and Young Practitioners Sub-committee (with a reduction of two in the number of coopted members) and to add the Chairman of the General Medical Services Committee (Scotland) ex officio".<sup>776</sup>

THE REVIEW BODY RESIGNS

In February 1969 the Tenth Report of the Review Body was published<sup>777</sup>. It gave a general increase to all doctors to compensate for changes in wages and salaries elsewhere and it was accepted by the G.M.S.C.<sup>778</sup>

The Government delays a Report

The Review Body continued taking evidence throughout 1969 with a view to reporting in the Spring of 1970. On May 11 1970 Dr. Stevenson, Secretary of the B.M.A., wrote to the Prime Minister to impress on him the need for dealing with the Report without further delay. Having received a non-committal response "that the Government had not completed its consideration of it", he wrote again "that the Government's reply was deplorable".<sup>779</sup> He reminded Mr. Wilson that the Conference of Local Medical Committees was meeting on May 27 and would expect to have firm news for its consideration<sup>780</sup>. During the same week the Government announced that a general election was to take place.

On the Friday evening immediately preceding the Spring Bank Holiday Dr. Stevenson received a letter from the Prime Minister informing him that the Government had decided that it would not be right to continue its consideration of the Report during the election period. This letter was released by the Government for publication in the National Press<sup>781</sup>. In spite of the fact that most of the B.M.A.'s staff had already gone away the Secretary managed to alert the profession's leaders and also to contact the press. He said

that Mr. Wilson's action would tax the credulity of the doctors, who were already suspicious of the Government's real intentions. "Twice in four years the Government had placed Review Body recommendations in cold storage, but on this occasion the Government had had the relevant Report for nearly seven weeks before the election date was announced." Anger mounted within the profession and the dispute between the Government and the profession acquired political overtones when the Opposition's spokesman on health matters, Lord Balneil, said that the doctors should be told why the Report had been swept under the carpet<sup>782</sup>.

On Tuesday, May 26, after a meeting of the Action Committee which had been set up by the Chairman of Council, a further press statement was issued which called for the immediate publication of the Report, failing which the Council would be recommended to advise the profession that all cooperation with the Government should cease forthwith and all doctors, both in general practice and in hospitals, should cease to give certificates for incapacity. Leaders of the profession met the Secretary of State on the evening of May 26 and arrangements were made for them to see the Prime Minister. Announcing this in Parliament Mr. Crossman said that he had made it clear to the doctors on May 22 that there could be no question of publishing the Report alone, but the Government was willing to review the publication of the Report, and the Government's views on it, with the profession before the election. This statement was attacked by both Lord Balneil and Mr. Maudling<sup>783</sup>.

The Annual Conference opened at 10 a.m. on Wednesday, May 27 and agreed immediately to suspend its standing orders in order to consider the position which had arisen in connection with the delay in publication of the Twelfth Report. Oral statements were made by the Secretary of the Association, the Chairman of the G.M.S.C. and the Chairman of Council. The Conference pledged its full support for the action proposed to secure the immediate publication and implementation of the Report. It deplored the decision to postpone the publication, which showed a cynical disregard of the fundamental agreement between the profession and the Government amounting to a breach of faith. If the situation were not immediately corrected it would destroy the confidence and goodwill which the Royal Commission had regarded as an essential basis of professional participation in the National Health Service. A motion on these lines was carried unanimously and a further motion that the text of the statement be made available to the press was carried by 88 votes to 81.<sup>784</sup>

When the leaders of the professions met Mr. Wilson on the 28th he agreed to publish the Report and the Government's views on June 4. The B.M.A. warned him that any refusal by the Government to accept the Report in full would have disastrous effects. The Council would continue its preparations for both the withdrawal of all cooperation with the Government and advising doctors not to sign sickness benefit certificates.\* Dr. Stevenson wrote to

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\* The Times commented "the next few days will be anxious ones for every doctor in the country, the British Medical Association admits.

every doctor in the country on June 1 acquainting them with the steps that had been taken up to that date, and asking for their support<sup>785</sup>.

The Twelfth Report of the Review Body,<sup>787</sup> which had been signed on March 31 1970, was published as arranged. It recommended a 30% increase for all doctors and stated that it did so in the knowledge of the Government's incomes policy. The Government agreed to pay the 30% to junior hospital doctors, but it did not accept the award to general practitioners and consultants. It decided that 15% should be paid at once and the other 15% would be referred to the Prices and Incomes Board for further consideration. In the early hours of June 5 the entire membership of the Review Body resigned because they considered that the Government's actions had made it impossible for them to function<sup>788</sup>.

#### The profession imposes sanctions

Dr. Stevenson warned that abolition of the Review Body would be considered as a resignation issue by the profession. Mr. Wilson accused the professions of "bidding it up" during the election; Mr. Heath, leader of the Conservative Opposition, asked if the

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But the crisis has welded the doctors into a formidable fighting force." Dr. Gibson, Chairman of Council, was quoted as telling the Prime Minister on the 27th, "We must thank you Mr. Prime Minister for doing something we have never managed to do; you have united the profession."<sup>786</sup>

Government's inability to pay was due to an impending economic crisis<sup>789</sup>. A copy of the Review Body's Report, the Government's statement and the profession's evidence was sent to all general practitioners and hospital doctors in the National Health Service, along with a message from the trustees of the British Medical Guild. The trustees advised all doctors that, from June 10 onwards, they should withdraw all cooperation in the administration of the National Health Service, including Executive Councils, regional hospital boards, boards of management, tribunals etc. and cease to sign any certificates of incapacity for work both Government and private<sup>790</sup>.

In some areas doctors began non-cooperation immediately; for example, 400 doctors in East Suffolk and Ipswich took action forty-eight hours before the deadline set by the B.M.A.<sup>791</sup>

In view of the impending newspaper strike,\* the British Medical Guild inserted large advertisements in most national daily papers on June 7 under the heading, "The bitter pill doctors are being asked to swallow". These advertisements gave the public the facts as the profession saw them. Meetings of doctors were held all over the country<sup>792</sup>. They were extensively reported in the local press which was not affected by the newspaper stoppage.

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\* The printing unions were negotiating with the Newspaper Publishers Association for a rise in pay. The strike was due to take place on June 10<sup>788</sup>.



For example, a meeting of 170 doctors in Hertfordshire supported the action taken by the Guild and following a press conference given by the officers of the Local Medical Committee the matter was reported, and commented upon, by a provincial evening newspaper the "Evening Echo"<sup>793</sup> and weekly newspapers circulating in the County<sup>794, 795, 796, 797</sup>.

Similarly there was ample television cover of the crisis; for example, the BBC.2 "Money Programme" on June 4 1970 included a discussion between a general practitioner, a consultant and a junior hospital doctor on the crisis.

On June 12 the British Medical Guild issued its Message No. 2<sup>798</sup> along with a ballot form asking the opinion of general practitioners and hospital doctors as to whether the threat to the continued existence of an independent Review Body would be a reason for resignation from the National Health Service. The Times reported that the B.M.A.'s attitude had hardened and that there was overwhelming support for non-cooperation<sup>799</sup>.

Although the result of the referendum\* could not be made available until June 27, by which time the Annual Representative Meeting would be in progress, the meetings of doctors attracted the biggest attendance since the crisis of 1956/7<sup>800</sup>. A meeting at BMA House on June 16 was attended by over 500 doctors who urged

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\* The referendum was labelled as irresponsible by the M.P.U.<sup>802</sup>

# BRITISH MEDICAL GUILD

## REVIEW BODY REPORT

Message No. 1 to all general practitioners and hospital doctors in the N.H.S. from the Trustees of the Guild

Enclosed with this letter is the Twelfth Report of the Review Body on Doctors' and Dentists' Remuneration together with the statement made by the Government on 4th June setting out their decision on the Report.

The B.M.A. is also sending to every general practitioner a copy of the written evidence which was submitted on his behalf. Similarly hospital doctors will find with this letter the case made by the B.M.A. for Hospital Medical Staffs.

The Report is a complete vindication of all that the B.M.A. has maintained for many years and it is deplorable that the Government should so soon again seek to interfere with the findings of an independent Review Body.

After twelve years of acrimonious negotiations on doctors' pay the Government accepted the recommendation of a Royal Commission that the remuneration of family doctors and hospital staffs in the National Health Service should be settled, not by public dispute, but by the periodical awards of an independent Review Body. The Royal Commission wrote:

"Doctors and dentists . . . have a right to receive fair treatment and to know whether they are receiving it . . . Doctors and dentists in the public service should not be used as a regulator of the national economy. Their earnings should not be prevented from rising because of a fear that others might follow . . . The second aim is to give these two professions, most of whose members derive the greater part of their livelihood from the National Health Service, some assurance that their standards of living will not be depressed by arbitrary Government action . . . we believe that seven people such as we have in mind will make recommendations of such weight and authority that the Government will be able, and indeed feel bound to accept them".

The Royal Commission also stated:

"It (the Review Body) must be regarded as a better judge than either the Government or the representatives of the professions as to what the levels and spread of medical and dental remuneration should be. While the Government cannot abrogate its functions and responsibility for ultimate decisions, we are insistent that the recommendations of the Review Body must only very rarely and for most obviously compelling reasons be rejected".

In 1966, the recommendations of the Seventh Report of the Review Body were substantially modified by the Government. The medical profession accepted the modifications, at a

sacrifice of millions of pounds of hard-earned remuneration, because of the critical state of the national economy at that time.

Now for the second time in four years the Government has tampered with an award of the Review Body. This time, being embarrassed by the size of the award, the Government has decided to refer part of it, for a second adjudication, to another umpire of its own choosing, the National Board for Prices and Incomes.

Thus, in one day, by its arbitrary decision the Government has succeeded in forfeiting the trust and co-operation of the medical profession and destroying the one body which has done so much to sustain the viability of the Health Service in the last ten years. The resignation of Lord Kindersley and all the members of the Review Body is a tragic blow to the profession, but it is a clear indication to the B.M.A. Council of the rightness of the stand it has taken to obtain justice for the profession. There could be no clearer indication of the gravity of the crisis of confidence which the Government has precipitated in the National Health Service.

The B.M.A. Council has protested in the strongest terms against the attempt by the Government to pay out increases in salaries and fees to N.H.S. doctors without, in accordance with normal practice, first ascertaining the views of the representatives of the profession.

It has requested the General Medical Services Committee to undertake no consultations under Regulation 22 of the General Medical and Pharmaceutical Services Regulations.

It calls upon all doctors in the N.H.S. to refuse any increases until (a) the continuation of the independent Review Body, with the scope and status defined by the Royal Commission is assured, and (b) the Government has agreed to implement the Review Body's Twelfth Report in full, without reference to any other tribunal.

Thus this dispute is not about levels of pay but about the sanctity of agreements. In this very serious situation the B.M.A. Council believes that the profession would rightly expect a firm stand to be taken.

The Trustees of the Guild therefore advise all doctors in Great Britain to take the following action with effect from WEDNESDAY, 10th JUNE, 1970. The steps recommended here WILL NOT INTERFERE WITH THE TREATMENT OF PATIENTS, which will continue as usual.

**Withdrawal of Co-operation in the  
Administration of the National Health Service**

1. Doctors are urged not to participate in any negotiating, advisory and administrative bodies (together with their committees and subcommittees) connected with the National Health Service, both central and local, including:

Central and Scottish Health Services Councils and their committees  
Medical Practices Committees  
Advisory Committees on Consultant Establishments  
Boards of Governors  
Regional Hospital Boards  
Boards of Management  
Hospital Management Committees  
Executive and Divisional ("Cogwheel") Committees  
Investigating Panels (under H.M. (61)112)  
Advisory Appointments Committees  
Local Executive Councils  
Medical Service Committees  
Tribunals constituted under the N.H.S. Acts.

Medical members (including chairmen) of any such bodies should inform the Secretary or Clerk that, until further notice, they will not attend any meetings or carry out any related functions.

2. Committees composed entirely of doctors should continue to meet, but should not perform any advisory functions to the Government or its agencies. Local Medical Committees should not carry out any of their investigatory functions (into excessive prescribing, certification, record keeping, etc.) nor consider complaints against medical practitioners.

3. Local authorities are not affected. Doctors should continue to serve on local authorities or other bodies and committees connected with them (including Whitley Committee 'C').

**Withdrawal of Incapacity Certification**

4. It is recommended that no National Insurance or private certificates of incapacity for work should be issued by doctors, or be authorised for issue by any agent (e.g. a ward sister) on behalf of a doctor. This applies only to certificates of incapacity for work, i.e. Forms Med. 3, Med. 5, and Med. 10, together with all private certificates of incapacity for work.

5. All other certificates should be issued as usual, e.g. certificates for expected confinement (Form Mat. B1), for confinement (Form Mat. B2), for special or welfare foods, and to certify inability to travel, to attend school, or to sit on a jury. Certificates should not be withheld from children under fifteen, or from pensioners and persons over retirement age.

6. Patients who are refused certificates should be advised to contact their local office of the Department of Health and Social Security. The Department has machinery for considering claims without medical certification, which was in operation on a limited scale last December (during the influenza outbreak). If a private certificate of incapacity is requested for an employer, for a trade union, or for any other purpose, the patient should again be advised to contact the local Social Security office. Advertisements will appear in the national Press on Wednesday, 10th June to explain the situation to patients and the general public. A poster for use in surgery premises and in hospitals is enclosed. Further copies can be obtained from the Secretary of the British Medical Guild at B.M.A. House.

7. It is appreciated that failure to supply National Insurance certificates is a breach of the terms of service of N.H.S. doctors; nevertheless the Trustees are in no mood to be deterred from advising the profession to proceed. The situation is so serious that direct action of this kind is fully justified.

**Further Action**

The Trustees of the British Medical Guild regard these two steps as fully justified by the support received from the profession about the Government's flagrant breach of faith. The Trustees hope that these steps will prove sufficient to convince the Government of the profession's determination and unity.

Nevertheless the B.M.A. Council is firmly of the opinion that the profession's participation in the N.H.S. must be dependent upon the continued existence of the independent Review Body and the honouring of its awards in the terms defined by the Royal Commission without reference to any other tribunal.

The B.M.A. Council believes that if this is not achieved the profession must withdraw from the N.H.S. and an immediate referendum is to be conducted by the British Medical Guild to confirm the profession's support for this view.

By Order of the Trustees,

6th June, 1970.  
B.M.A. House,  
Tavistock Square,  
London, W.C.1.

# BRITISH MEDICAL GUILD

## THE REVIEW BODY

### Message No. 2 to general practitioners and hospital doctors

Message No. 1 (issued on Monday, 8th June) described the crisis of confidence which the Government had precipitated in the National Health Service by refusing to honour the award of the independent Review Body and referring part of it to the P.I.B. The message ended by stating that an immediate referendum was to be conducted about the continued existence of the independent Review Body and the honouring of its awards.

Appended to this Message are some brief notes on the Independent Review Body, and on Withdrawal from the N.H.S.

Also enclosed is a ballot paper.

The Trustees wish to emphasise that this ballot paper is not a form of resignation from the N.H.S. It is a form for an expression of opinion.

The views expressed by the profession will be reported to the Representative Body of the B.M.A. Only after the most careful consideration of the profession's views will the Trustees be enabled to decide the circumstances in which they would be justified in seeking the profession's agreement to the ultimate step of withdrawal from the N.H.S.

Contingency plans for possible withdrawal are being made. As an example, brief details of one such plan are given overleaf.

By Order of the Trustees,

B.M.A. House,  
Tavistock Square,  
London W.C.1  
12th June, 1970.

### Some Notes on the Independent Review Body

The first decade of the National Health Service was marred by successive public disputes about the remuneration of the doctors and dentists participating in it. Eventually, the matter was referred to the Royal Commission on Doctors' and Dentists' Remuneration, which sat for three years and reported in 1960.

The Royal Commission recommended that henceforward the remuneration of doctors and dentists in the N.H.S. should be settled by an independent Review Body. The Royal Commission wrote:

"13. We recommend the setting up of a Review Body, somewhat similar to the Advisory Committee on the Higher Civil Service, to watch the levels and spread of medical and dental remuneration, and to make recommendations to the Prime Minister. The main task of this Body will be the exercise of the faculty of good judgment, and it must be composed of individuals whose standing and reputation will command the confidence of the professions, the Government, and the public. It must be regarded as a better judge than either the Government or the representatives of the professions as to what the levels and spread of medical and dental remuneration should be."

"14. While the Government cannot abrogate its functions and responsibility for ultimate decisions, we are insistent that the recommendations of the Review Body must only very rarely and for most obviously compelling reasons be rejected."

These paragraphs, in common with the rest of the Royal Commission's Report, were accepted by I.I.M. Government and the profession.

Other relevant extracts from the Report of the Royal Commission are these:

"Doctors and dentists. . . have a right to receive fair treatment and to know whether they are receiving it."

"Doctors and dentists in the public service should not be used as a regulator of the national economy. Their earnings should not be prevented from rising because of a fear that others might follow."

"But we are satisfied that the appointment of such a body is the only means of achieving the three aims to which we referred at the beginning of this chapter — the settlement of remuneration without public dispute, the provision of some assurance for the professions that their remuneration is not determined by considerations of political convenience and the provision of some safeguard for the community as a whole against medical or dental earnings rising higher than they should."

"But we believe that seven people such as we have in mind will make recommendations of such weight and authority that the Government will be able, and indeed feel bound, to accept them."

"Their (the professions') remuneration will be determined, in practice, by a group of independent persons of standing and authority not committed to the Government's point of view."

The Review Body was appointed in 1962 and has issued 12 reports as follows:

1st Report (1963)	General.
2nd Report (1964)	Remuneration of Dentists.
3rd Report (1965)	Remuneration of S.H.M.O's.
4th Report (1965)	Distinction Awards.
5th Report (1965)	Remuneration of General Practitioners.
6th Report (1965)	Remuneration of Dentists.
7th Report (1966)	General.

The Government decided to phase the general practitioners' award into two parts, one with effect from 1st April, 1966, the balance to be paid from 1st April, 1967. Subsequently phase one of the general practitioners' award and the whole award for hospital staffs were postponed for six months as a result of the Government's pay standstill.

8th Report (1967)	Distinction Awards.
9th Report (1968)	General.
10th Report (1969)	General.
11th Report (1969)	Distinction Awards.
12th Report (1970)	General.

The Report was in the hands of the Prime Minister on 2nd April, 1970. On 23rd May, Mr. Wilson, in reply to representations from the B.M.A., stated that he had decided to defer publication until after the General Election. On 28th May, further strong representations from the B.M.A. and B.D.A. were made and Mr. Wilson agreed to bring forward the date of publication. The Report was published on 4th June with the Government's decision, which was to pay out the whole award to hospital junior staff but only half the award to hospital senior staff and general practitioners, the remainder of the award to them being referred for a "second opinion" to the National Board for Prices and Incomes.

The members of the Review Body at the time of their recent (twelfth) report were:

The Lord Kindersley, C.B.E., M.C., Chairman  
 Arthur Bagnall, Esq., M.B.E., Q.C.  
 Michael Clapham, Esq., M.A.  
 Professor S. R. Dennison, C.B.E., M.A.

J. H. Gunlake, Esq., C.B.E., F.I.A.  
 David F. Landale, Esq.  
 Geoffrey Templeman, Esq., M.A., PH.D.

*All these members resigned en bloc on 4th June, 1970.*

## Brief Notes on Withdrawal from the National Health Service

Withdrawal will not be contemplated by the Trustees unless at least 50% of those voting in this Referendum have answered "Yes" to question 4 of the ballot paper.

Withdrawal of doctors from the N.H.S. need involve no interruption in the medical care of the community.

There is nothing to stop doctors from practising their profession outside the N.H.S.

### General Practitioners

General Practitioners are required to give three months' notice of withdrawal from the Executive Council List. At the expiry of the period of notice, they would continue in practice, charging fees for each item of service (a schedule of recommended fees would be issued by the B.M.A.). A receipt for each fee would be given so that, should the Government decide to continue to meet the cost of medical care, the patient could take the receipt to the local office of the Department of Health and Social Security and apply for reimbursement. It is anticipated that the Government would not wish to deprive the public of the benefits of the N.H.S. Pharmaceutical Service. Posters and leaflets of advice to patients would be made available by the Guild.

### Hospital Doctors

Hospital doctors would give the length of notice specified in their contracts or letters of appointment (usually from one to three months). At the expiry of the period of notice, the doctor could offer his services to the same employing authority. He would be free to make his own terms with the hospital authority, but clearly he should require a rate of remuneration not less than that laid down for his present appointment by the Twelfth Report of the Review Body; and other terms at least as good as those laid down in the Terms and Conditions of Service for Hospital Medical and Dental Staff. Model contracts would be issued by the B.M.A.

### No Detriment

As explained at the beginning of this document the completion of this present ballot paper commits no-one to withdrawing from the N.H.S. If the profession were to decide to withdraw from the National Health Service, and did so, an essential part of any ultimate settlement would be a general "no detriment" clause.

### Superannuation

Doctors below the age of 60 would have the following options:

- to leave their superannuation contributions untouched. If they returned to the N.H.S. within one year, their superannuation rights would be unaffected.
- to claim a refund of their superannuation contributions, with compound interest, but less tax. Application should be made to the Health Services Superannuation Division, Department of Health and Social Security, Hesketh House, 200 - 220, Broadway, Fleetwood, Lancs. They might then wish to insure privately against retirement, and for other benefits. The Medical Insurance Agency in B.M.A. House has considerable knowledge of these matters.
- to apply for membership of the Federated Superannuation Scheme. There are regulations which enable persons on leaving the N.H.S. to transfer intact the accumulated benefits earned in the N.H.S. Superannuation Scheme, thus permitting the continuity of superannuation provision. Moreover, a "transfer value" payment can be made back to the N.H.S. Superannuation Scheme provided the person re-enters the N.H.S. within five years.

Doctors aged 60 or over, who have at least ten years' service in the N.H.S., would also have the option to claim their N.H.S. pension and lump sum retiring allowance immediately. Such doctors who subsequently returned to work in or for the N.H.S. would thereby qualify for a second N.H.S. pension.

### Compensation

A general practitioner who withdraws from the N.H.S. may immediately claim any practice compensation that may be due to him on application to the Department of Health and Social Security, Eileen House, 80 - 94, Newington Causeway, London, S.E.1.



support for the referendum<sup>801</sup> and on the same day the Government revealed that 18,000 out of 24,000 general practitioners were refusing to sign certificates<sup>803</sup>. As a further precaution the B.M.A. established a contingency fund<sup>804</sup>.

#### A compromise with a new Government

The election resulted in a victory for the Conservative Party. The closing date of the ballot was extended and the Association commissioned a Marplan poll to ascertain how much support there was within the profession for its actions. Before the commencement of the Representative Meeting the Association claimed that it had made no approach to the new Government, but on June 26 the profession's leaders left the Annual Representative Meeting at Harrogate and travelled to London to meet Sir Keith Joseph, the new Secretary of State, at the Cabinet Office at 2 p.m. At the same time, in Harrogate, moves to persuade the Representative Body to call off the sanctions were squashed<sup>805</sup>.

A Special Representative Meeting on the morning of Saturday, June 27, accepted a formula for ending the dispute by an overwhelming majority. The reference to the Prices and Incomes Board was to be withdrawn and negotiations were to take place on the 15% which had been referred to it. There was speculation that the profession would receive 7½%, which turned out to be almost correct. It was also announced that of the 55,049 ballot forms which had been sent out only 26,219 had been returned;\*

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\* The Council decided not to publish an analysis of the referendum.

of these 16,754 were in favour of resignation, 7275 were against and 2190 were spoilt<sup>806</sup>.

The representatives of the profession met Sir Keith Joseph on July 10 and heard from him why it was necessary for further negotiations to take place on the 15% that the Labour Government had been unable to pay. The Times thought the differences between the branches of the profession might be exposed<sup>809</sup>. This opinion was shown to be correct when the Regional Consultants and Specialists Association insisted that the outstanding 15% should be paid<sup>810</sup>.

The profession was offered 5% towards the outstanding 15%. This meant that the general practitioners received 20% of the 30% originally recommended by the Kindersley Review Body<sup>810a</sup>. The G.M.S.C. accepted the Government's modification of the increases in general practitioners' pay, reserving the right to re-open the question in the light of the Government's attempts to counter inflation<sup>811</sup>. Sir Keith Joseph notified the B.M.A. that he

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At a meeting of the G.M.S.C. a motion that the Council be recommended to publish the full results of the referendum, was rejected by 25 votes to 20<sup>807</sup>. A draft report of the Prices and Incomes Board showed that the Board had been highly critical of the statistical evidence adduced by the Review Body, but because of the Government's action in withdrawing the reference this report was never published<sup>808</sup>.



would arrange an early meeting to discuss the establishment of a new Review Body which would be linked with other machinery which was being set up to advise the Government on pay in the public sector<sup>812</sup>. A new Review Body was appointed on July 5 1971 under the chairmanship of the Earl of Halsbury. It reported in the following October<sup>813</sup>.

THE REORGANISATION OF THE NATIONAL HEALTH SERVICE

The National Health Service established by the 1946 Act was based on a tripartite system consisting of the hospital service, the executive council services and the health services provided by the local authorities, with no statutory provision for coordinated decision making.

The Messer Committee set up by the Central Health Services Council in 1950 to report on existing forms of cooperation between the various administrative bodies concluded that no change in the "authority" structure of the National Health Service was necessary to achieve better coordination. However the Committee proposed setting up general standing joint liaison advisory committees to discuss local health arrangements of mutual interests<sup>814</sup>. Two years later the Cohen Committee on General Practice agreed with this assessment<sup>815</sup> in so far as it concerned general practitioners and in 1956 the Guillebaud Committee came to a similar conclusion about reorganisation, rejecting suggestions from a minority of its witnesses that the Service should be unified in whole or in part<sup>816</sup>.

In 1962 the Committee to Review the Medical Services, chaired by Sir Arthur Porritt and sponsored by the B.M.A. and the Royal Colleges, decided that the tripartite division of the Health Service was harmful to its proper development and should be replaced by unified administrative units to be called Area Health Boards. There should be Regional Planning Committees at a level

between the area health authority and the Ministry<sup>649</sup>. In 1963 the Annual Representative Meeting instructed the Council to support the setting up of Area Health Boards as they would increase coordination and cooperation between the three parts of the Service<sup>635</sup>. This decision was amplified at the Annual Representative Meeting of 1968 when it was resolved that "the administration of the three branches of the National Health Service be unified in Area Health Boards, which should also be responsible for the administration of all local authority and welfare services, but that the freedom and liberty of general practitioners as independent contractors be preserved at all costs in any future contract with Area Health Boards".<sup>776</sup>

In 1965 the Association's Welsh Committee put forward detailed proposals for using Wales as a pilot scheme for Area Health Boards, and at the Annual Conference the following motion was carried as a reference to the G.M.S.C.:-

"That this Conference requests an early review of the administrative system of the National Health Service, with a view to unification of the three branches of the Service, believing this to be a necessary prerequisite for the economic and balanced development of an efficient and progressive Health Service to which all doctors would be proud to belong." <sup>705</sup>

#### The first Green Paper

In November 1967 the Minister of Health, Mr. Kenneth Robinson, announced that he was making a careful examination of the administrative structure of the medical and related services for

which he was responsible, and on July 23 1968 a "Green Paper" outlining his proposals was issued for the purpose of discussion and consultation<sup>817</sup>.

Following the Minister's announcement the Council of the B.M.A. established a working party to consider National Health Service reorganisation, which reported to the Council on June 5 1968. The Working Party suggested that in an area authority with twenty-five members at least eight should be doctors elected by the profession, including at least one from a university or teaching hospital, and that any Chief Executive Officer should be medically qualified. It agreed with the Porritt Report (Paragraph 83) that there should be a pilot scheme with continuous evaluation of the effectiveness of area health authority administration<sup>818</sup>.

The Council referred the Working Party report to the standing committees. Many members of the G.M.S.C. expressed serious misgivings about certain of the proposals in the report. It was agreed that the Council should be informed that the Committee could not agree to the document being used in the way that Council had suggested, i.e. to provide guidelines for the Association's representatives, allowing them a degree of flexibility in their discussions with the Ministry. In order to give members more time to study the report, it was agreed that detailed consideration would be deferred until a special meeting<sup>819</sup>.

This was held on September 5. The Chairman reminded the Committee of the resolution of the Conference of 1965 concerning a unified Health Service. He gave an assurance to Local Medical Committees

that no discussions had taken place with the Government on its document, and that no such discussions would take place until the views of general practitioners had been obtained. The Committee then debated the matter for three hours after which it appointed a working party to give detailed consideration to the proposals in the Green Paper, taking into account the recommendations contained in the Seebohm Report,<sup>\*</sup> other relevant reports, and the report of the Royal Commission on Local Government when published. Local Medical Committees and members of the G.M.S.C. were invited to submit memoranda on the proposals for consideration by the working group<sup>821</sup> and fifty-four Local Medical Committees and three individuals submitted evidence.

The Working Party was convinced "that proposals for administrative change must not be accepted if their implementation will endanger the full preservation of these principles:-

1. the objective of any change must be improvement of the Service for the community;

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<sup>\*</sup>In July 1968 the report of the Seebohm Committee, which had been appointed in 1965 "to review the organisation and responsibilities of the local authority personal social services in England and Wales and to consider what changes are desirable to secure an effective family service" was published<sup>820</sup>. It recommended that there should be a unified social work unit within each major authority.

2. the independent contractor status of the family doctor - necessarily implying freedom of choice between patient and doctor - must be maintained;
3. whatever the circumstances absolute confidentiality both between patient and doctor and between doctor and doctor must be maintained;
4. the clinical independence of the family doctor must not be impaired;
5. the relationship between Government and the medical profession should be one of genuine partnership - providing for agreement in planning and participation in administration."<sup>822</sup>

These became known as "the fundamental principles of general practice" and were accepted by the G.M.S.C. as policy.

The Committee informed the Conference that the detailed proposals of the Green Paper were unacceptable as a basis for the reform of the National Health Service and that the existing tripartite structure should be maintained. Area Boards should be charged in the main with the evaluation of services and planning, and half their members should be elected by the professions.

The Conference rejected by 72 votes to 98 a motion by Hertfordshire Local Medical Committee that "a unified administration of the National Health Service is desirable" but accepted an amendment from Wolverhampton which altered the G.M.S.C.'s recommendation to read "that the existing tripartite administrative structure should be retained until a new structure has been agreed". The Conference modified the detailed wording of other recommendations

of the G.M.S.C., but it endorsed the basic principles which they contained<sup>823</sup>.

The Council of the B.M.A. considered the views of the standing committees on the administrative structure of the National Health Service, and prepared a report for consideration at a Special Representative Meeting to be held on January 30. It included in its consideration the Report of the Seebohm Committee, and concluded that there must be medical supervision of all social work with a predominantly health content and purpose, as well as of all para-medical services (including supplementary and auxiliary medical services). It endorsed the G.M.S.C.'s "fundamental principles" but recommended that, provided there were satisfactory safeguards on major points of principle, the Representative Body should reaffirm its support for the principle of the unification of the administration of the Health Services<sup>824</sup>. Council's report was accepted by the Representative Body with minor modifications; it confirmed "that the existing tripartite structure of the National Health Service should be retained until such time as a suitably negotiated and agreed alternative has been accepted by the profession".<sup>825</sup>

#### Reorganisation of Local Government in England

The Report of the Redcliffe-Maud Commission on Local Government in England\* was published on June 11 1969<sup>826</sup>. The three cardinal

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\* A shortened form containing the essentials of the evidence,



principles in the Report, that a major rationalisation of Local Government was called for, that a marked reduction in the number of units with executive responsibility was needed, and that the anachronistic division between town and country should be ended, were accepted by the Government. The Redcliffe-Maud Commission had suggested that consideration should be given to unifying responsibility for the National Health Service within the new system of local government but in the White Paper the Government made it clear that this was not practicable<sup>828</sup>.

### Second Green Paper

During 1969 consultations took place between the Secretary of State for Social Services and the representatives of the medical profession<sup>829</sup> and other interests. Members of the Management Committee of the Association of English Executive Councils met Mr. Crossman, the Secretary of State for Health and Social Services, and other Ministers. They were informed that the Secretary of State had set up a working party to consider revised proposals for the reorganisation of the National Health Service and that a second Green Paper was to be published in the Autumn of 1969<sup>830</sup>.

The second "Green Paper" was published in February 1970. The Secretary of State admitted that there had been strong criticism of the proposal in the first Green Paper. He proposed that the

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arguments and conclusions was also issued<sup>827</sup>.

National Health Service should be administered by area health authorities responsible to the Secretary of State and closely associated with local authorities. There should be district committees, and regional health councils which would plan some services, especially the hospital services, on a regional basis, organise postgraduate medical education and advise area health authorities and the Secretary of State. The area health authorities would have twenty to twenty-five members of whom one third would be appointed by the health professions. The family practitioners' status as an independent contractor would be preserved. They would be in contract with "statutory committees", similar in composition to the executive council, which each area health authority would be required to establish<sup>831</sup>.

It was decided to call a Special Conference in May to consider the second Green Paper and the Report of the Royal Commission on Medical Education (The "Todd Report")<sup>832</sup>. On the instructions of the Chairmen of the Conference and G.M.S.C., the Secretary of the G.M.S.C., Dr. David Gullick, issued a provisional notice to Local Medical Committees<sup>833</sup>. This action was reported to the General Purposes Sub-committee<sup>834</sup> and to the main Committee<sup>835</sup>.

A working party was set up and its report, slightly modified, was adopted by the Committee as its report to the Special Conference. It recommended that the "fundamental principles" of general practice should be retained; there should be an inquiry into the financing of the National Health Service; area health authorities should include twelve members elected by the

profession and the composition of the statutory committees should be identical with that of the Executive Council, with power to appoint their own chairmen<sup>836</sup>. The Committee decided that the second Green Paper formed a basis upon which negotiations on the reorganisation of the National Health Service could take place and its recommendation was accepted by the Conference with only minor alterations<sup>837</sup>.

#### The "Consultative Document" of 1971

Following the election of a Conservative Government in the late summer of 1970 negotiations on the reorganisation of the National Health Service ceased. In May 1971 the Secretary of State for Social Services, Sir Keith Joseph, issued a "Consultative Document" on National Health Service reorganisation<sup>838</sup>. It notified the Government's intention to implement the changes in the Health Service on the same day as those affecting local government, i.e. April 1 1974. The Secretary of State proposed to introduce a new concept of "management" into the National Health Service with delegation downwards and accountability upwards through Regional Authorities appointed by the Secretary of State and Area Authorities appointed by the regions. Both tiers would have strong professional advisory machinery.

The Area Health Authorities' boundaries were to be coterminous with those of local authorities with whom they would work in close harmony; the family practitioner services would be administered by Family Practitioner Committees with a composition similar to that of the Executive Councils.

The Secretary of State announced his intention to establish two broadly based expert studies, one to examine the detailed management arrangements at each level of the Health Service and the other the relationships between the area health authorities and their corresponding local authorities. The Department asked those organisations who wished to comment on the Consultative Document to do so by the end of July 1971, i.e. two months after its publication.

The General Purposes Sub-committee considered the Consultative Document and the Government's firm proposals on reorganisation of local government in England<sup>839</sup>. It prepared a draft report for the G.M.S.C. which was approved<sup>840</sup>. The report reiterated the previous policy of the Committee. In addition it recommended that the negotiating machinery for general practitioners, including the right of the G.M.S.C. to negotiate directly with the Secretary of State and his officers, must be maintained, and that the Family Practitioner Committee must be established by statute. Local Medical Committees should be established and elected "as at present" and should elect members to the Area and Regional Health Authorities in an effective proportion<sup>841</sup>.

The Committee's recommendations were accepted by the Conference<sup>842</sup> and the decisions of the Conference were conveyed by the G.M.S.C. to the Representative Body of the Association at Leicester, which endorsed them<sup>843</sup>.

A White Paper and a Grey Book

The Management Study was carried out by a Study Group under the direction of a broadly based Steering Committee whose terms of reference were:-

"On the basis of the Government's consultative document on National Health Service Reorganisation, and taking account of other relevant studies commissioned by the Secretary of State to make recommendations of management systems for the services for which regional and area health authorities will be responsible and on the internal organisations of those authorities."

The Secretary of State appointed two general practitioners, Drs. J.H. Marks and C.J. Wells, both of whom were members of the G.M.S.C., to the Steering Committee and two more members of the G.M.S.C., Drs. W.G. Riddle and E. Colin-Russ were appointed to the working party on collaboration whose terms of reference were:-

"In the context of the proposed reorganisation of local government and of the National Health Service, to consider the need and scope for collaboration and coordination - including any factors likely to impede or prevent them - between the local authorities and the health authorities both from the point of view of those receiving services and the public generally, and in order to ensure the most effective and efficient use of staff, building, and other resources; and to make recommendations to the Government on these matters."

The Steering Committee met for the first time on August 5 1971. In January it issued a discussion draft<sup>844</sup> which was circulated

to all interested parties. The document was not sent to the B.M.A., which had appointed a working party to deal with the problem, but to the General Purposes Sub-committee of the Staff Side of the General Whitley Council, who transmitted it to the Association<sup>845</sup>. A meeting between representatives of the Association and Sir Philip Rogers, Permanent Under-Secretary of State and Chairman of the Steering Committee took place on February 8. The G.M.S.C. received a report of these developments from its Chairman and debated the discussion document<sup>846</sup>.

On June 22 Sir Keith Joseph, unaccompanied by his civil servant advisers, addressed the G.M.S.C. on the reorganisation of the National Health Service and answered questions put by members of the Committee<sup>847</sup>.

In August the White Paper on National Health Service Reorganisation in England was published<sup>848</sup> followed on September 5 by the report of the Steering Committee<sup>849</sup>. This, because of its unusual grey cover, became known as the "grey book". These two documents were considered by the G.M.S.C. which prepared a document for discussion by a Special Conference in November<sup>850</sup>.

The Conference accepted the concept of the "district management team", a fundamental part of the proposed management structure. The team would comprise a general practitioner and a consultant elected by their colleagues, and an administrator, a nursing officer, a treasurer and a community physician appointed by the Area Health Authority<sup>851</sup>. It welcomed the establishment of

Family Practitioner Committees, but insisted that the "Administrator, Family Practitioner Services", should be responsible to the Family Practitioner Committees and not to the Area Health Authorities as suggested in the Grey Book<sup>852</sup>.

Sir Philip Rogers attended a meeting of the G.M.S.C. accompanied by Dr. H. Yellowlees, Second Chief Medical Officer of the Department. Referring to the decisions of the Conference, Sir Philip explained how the new National Health Service would be organised, paying particular attention to the district management team and the Family Practitioner Committee. He emphasized that the clinical freedom of the doctors would not be destroyed. Both he and Dr. Yellowlees answered questions from members<sup>853</sup>.

At the same meeting the Committee held a "first reading debate" on the National Health Service Reorganisation Bill which had been introduced into the House of Lords. The Statute and Regulations Sub-committee were instructed to consider both the Bill and the Grey Book and liaise with the B.M.A. as a whole<sup>854</sup>.

The Statute and Regulations Sub-committee reported to the G.M.S.C. on the status of the Family Practitioner Committee whose functions, unlike those of executive councils, would not be written into the Act but would be covered by Regulations. The Committee instructed its negotiating team to seek a meeting with the Secretary of State to press for an amendment to the Bill<sup>855</sup>.

The Secretary of State accepted the general principles in the Grey Book subject to Parliament's decisions on the Bill. The



Administrator (Family Practitioner Service) would be accountable to the Family Practitioner Committee and arrangements would have to be agreed between the Area Health Authority and the Family Practitioner Committee for his attachment to the latter<sup>856</sup>.

On June 5 a Special Representative Meeting of the B.M.A. too recognised the significance and importance of the district management team and urged all clinicians to participate actively in their establishment<sup>857</sup>. The National Health Service Reorganisation Act 1973<sup>858</sup> received the Royal Assent on July 5 1973, exactly twenty-five years after the commencement of the Service.

## VOCATIONAL TRAINING FOR GENERAL PRACTICE

When the G.M.S.C. and the Conference accepted the inclusion of a Vocational Training Allowance as recommended in the Seventh Report of the Review Body in the "new" remuneration structure, they in fact accepted that there was an intrinsic need for postgraduate training before entering general practice and that future general practitioners should be encouraged to undertake it.

The G.M.S.C. appointed an Advisory Committee on Vocational Training and Continuing Education for General Practice under the chairmanship of Dr. D.C. Bowie. Its conclusions were included in the annual report of the G.M.S.C. published in April 1968, along with a report of the liaison committee of the Royal College of General Practitioners and General Medical Services Committee on the implementation of vocational training for general practice<sup>859</sup>. In essence the Committee recommended that after qualification the doctor in training should spend three years in approved hospital posts and one year in wholetime training in an active general practice. The Conference welcomed the plans for vocational training. It resolved that interim arrangements would be required prior to full implementation and that appointed teachers should be adequately rewarded for their work<sup>771</sup>.

### The "Todd" Report

Coincidentally the Report of the Royal Commission on Medical Education, which had been appointed in 1965, was also published in April 1968<sup>832</sup>. The Commission recommended inter alia that the

professional training of the British doctor should consist of one intern year, three years general professional training, and a period of further training merging into the normal responsibilities of a professional career. A commentary on the Report prepared by the Vocational Training and Continuing Education Sub-committee was considered by the G.M.S.C. and amended<sup>860</sup>. In the Spring of 1969 the G.M.S.C. published its views on the major matters in the Todd Report, on the statement by the General Medical Council on the proposals of the Royal Commission, and on the Government's Paper on the Administration and Finance of Postgraduate Medical Education<sup>861</sup>. The Committee's views were accepted by the Conference in June, which resolved that the G.M.S.C. should establish a special sub-committee to investigate in depth the implications of the Todd Report for general practitioners in the National Health Service<sup>862</sup>.

#### Specialist Registration and the Chief Medical Officer's letter

On July 24 the Secretary of State announced the Government's acceptance of the Royal Commission's recommendation that a system of specialist registration should be introduced, and its intention to introduce legislation to amend the Medical Act, so as to enable the General Medical Council to undertake the task. On September 8 the Chief Medical Officer, Sir George Godber, wrote to the Secretary of the B.M.A. informing him that the opportunity would be taken to include in the legislation certain other provisions, mainly concerned with giving effect to other recommendations made by the Royal Commission on Medical Education, which were not

directly related to specialist registration. It was proposed that multiple fees should be payable by applicants for specialist registration in order to meet the substantial administrative costs<sup>863</sup>. The G.M.S.C. refused to accept the degree of urgency suggested by the Chief Medical Officer and expressed its complete opposition to the introduction of further legislation in the forthcoming parliamentary session<sup>864</sup>.

It was obvious to the Council of the B.M.A. that these provisions went much further than had been envisaged from a study of the Todd Report and an immediate protest was made to the Secretary of State. A meeting took place between a deputation from the B.M.A., the President and other members of the General Medical Council, and the Chief Medical Officer and other senior members of the Health and Social Security Departments. These talks continued on November 6 1969 when the British Medical Association Council reported that it could not commit the profession until there had been full discussions with its members. On November 14 1969 the Secretary of State announced that he had decided to postpone the introduction of the Bill on specialist registration until at least the Autumn of 1970.

It had been the intention of the B.M.A. Council to have this matter fully discussed at the Annual Representative Meeting due to be held in the Summer of 1970 but when the President of the General Medical Council declined to hold up the Regulations to impose an annual retention fee beyond the middle of February 1970, the Council of the B.M.A. had no alternative but to convene

a Special Representative Meeting (at considerable expense to the B.M.A.'s members). The Association's Council insisted that the issue in question was whether the policy laid down in the following resolution of the Representative Body:

"That whilst appreciating the necessity for instituting an annual retention fee by the General Medical Council, it is felt that those doctors who have paid a life registration fee should not be asked to pay an additional fee in addition"

was to be varied.

The Council asked the Representative Meeting to approve two recommendations:-

1. that the Representative Body is not opposed to the introduction of an annual retention fee of £2 payable by all registered medical practitioners resident in the United Kingdom except those over 65 or prematurely retired on health grounds;
2. that the Representative Body believes that the profession's continued confidence in the General Medical Council must depend on the latter's acceptance of the Representative Body's policy that a majority of the members of the General Medical Council should be elected by the profession. 865

At the Special Representative Meeting held on February 12 1970 it was resolved, by the necessary two thirds majority required to change the Association's policy:

"That the Representative Body is not opposed to the introduction of an annual retention fee of £2 payable by registered medical

- practitioners who wish to be retained on the register, except those over 65 or prematurely retired on health grounds, or in any other special category agreed from time to time between the profession and the General Medical Council, provided that
- a) the General Medical Council shall contain a majority of members that have been directly elected by the profession;
  - b) there shall be adequate places for elected members on committees of the General Medical Council;
  - c) the Representative Body shall agree with the General Medical Council and the Government on the functions and composition of the General Medical Council and its committees following an immediate review thereof conducted jointly by the General Medical Council and the British Medical Association.\* 866

#### The Conference reviews its attitude to Vocational Training

Following the Chief Medical Officer's letter the G.M.S.C. re-examined the whole question of vocational training and vocational registration, and agreed that postgraduate vocational training was necessary for independent general practice and that

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\* The series of events which led to the establishment of the Brynmor Jones Working Party on the constitution of the General Medical Council, the Tunbridge Working Party on the functions of the General Medical Council and finally the Merrison Committee of Inquiry into the Regulation of the Medical Profession is outwith this study and is fully described in the Annual Report of the Council 1972/3<sup>867</sup> and the Association's Memorandum of Evidence to the Committee of Inquiry<sup>868</sup>.

it should be for a period of three years after the preregistration year. The principle of an indicative vocational register, which would serve only to indicate those general practitioners who had completed adequate training, was accepted. Initially the names of all principals in general practice should be entered in the Vocational Register and thereafter all those who had completed the course of vocational training approved by the Conference of Representatives of Local Medical Committees should be entitled to registration. The Committee refused to accept that the passing of an examination should be a prerequisite to vocational registration<sup>869</sup>. Later the Committee accepted in principle that there should be an initial registration fee and an annual retention fee. The vocational register for general practice should be maintained by the General Medical Council, provided that a majority of its members were elected by the profession and it was advised by a Specialty Board consisting predominantly of practising general practitioners. The General Medical Council should specify the standards needed for vocational registration but the arrangements for postgraduate education should remain the province of the universities, colleges, professional associations and the National Health Service. The latter should pay for the training facilities and the cost of the postgraduate councils and committees. The Committee emphasized that vocational registration should not start before all the facilities needed for it were available<sup>870</sup>.

The Committee's report embodying these decisions<sup>871</sup> was submitted to a Special Conference on May 5 1970 and was approved. The Conference expressed its opposition to mandatory vocational



training following the preregistration year and to the idea that the General Medical Council should enlarge its functions to include the supervision of postgraduate training or education. It insisted that a medical practitioner must be regarded as qualified to practise his profession independently from the date of full registration; legislation to introduce vocational registration was neither necessary nor desirable<sup>837</sup>.

In 1971 the Committee reported that there was a growing number of comprehensive vocational training schemes in various parts of the country. These were bringing to light a number of problems which required to be solved. The Department of Health and Social Security had established a Council for Postgraduate Education on the broad lines suggested by the Royal Commission, but the G.M.S.C. were of the opinion that its constitution did not provide for adequate general practitioner representation. The Committee nominated its chairman and Dr. Weller to serve on the Council with Drs. Gethen and Ball as deputies.

The Committee's proposal for a special general practice advisory committee to advise the Council was accepted. It would include members of the G.M.S.C. and the Royal College of General Practitioners along with a postgraduate dean, a clinical tutor and a representative of the hospital junior staffs.<sup>872</sup>

A working group under the chairmanship of Dr. Riddle which had been established to review the remuneration structure described in the third joint report decided that the vocational training

allowance was totally inadequate and in fact acted as a disincentive because of its relationship to seniority awards. The group recommended that the situation should be remedied by an interest free loan, to be granted on entering general practice to all who had completed a recognised course of vocational training<sup>873</sup>.

The Conference emphasized that the financial rewards of vocational training were totally inadequate and needed improving<sup>874</sup>.

The following year it recommended that the General Medical Services Committee should make "strenuous efforts to have sufficient schemes of vocational training for general practice introduced in order that, by definite date, not later than 1977, vocational registration for general practice can be implemented".<sup>875</sup>

THE INDUSTRIAL RELATIONS ACT

On October 5 1970 the Government, in accordance with its election promises, issued a Consultative Document relating to a proposed Industrial Relations Bill. It was the Government's intention to amend the law relating to employers and workers, and to organisations of employers and organisations of workers, and to promote good industrial relations.<sup>876</sup>

The General Purposes Sub-committee of the G.M.S.C. considered the Document and realised that it was essential to ascertain the Association's liability under the proposed new legislation<sup>877</sup>. The Association was prevented by its Memorandum of Association from becoming a trade union\* yet it undoubtedly negotiated with employers on behalf of the profession. The Consultative Document showed that the Government had no intention of allowing a limited company to register as an "organisation of workers".<sup>879</sup> In early discussions the Department of Employment made it quite clear that the Bill was intended to cover the medical profession, including both salaried doctors and general practitioners, that

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\* Paragraph 3 of the Memorandum ended with the words, "provided that the Association shall not support with its funds any object or endeavour to impose on or procure to be observed by its Members or others any regulation, restriction or condition which if an object of the Association would make it a trade union".<sup>878</sup>

the only form of registration under the Bill would be as a trade union, and that the B.M.A. under its existing constitution was ineligible. The Chairman of the G.M.S.C., and other representatives of the B.M.A. and the British Dental Association, met the Secretary of State for Social Services and the Secretary for Employment and Productivity, Mr. Robert Carr, for further discussions on the problem<sup>880</sup>.

### The Special Register

The Industrial Relations Bill was introduced in the House of Commons on December 1. On December 17 the Secretary of the Association reported to the G.M.S.C. that discussions were taking place between the solicitors for the Government and the Association to consider amendments which could be made in the Bill to safeguard the position of the profession and the Association<sup>881</sup>. At the request of the Secretary of State for Social Security, the Deputy Secretary of the Association telephoned him and was informed that the Government had decided to table amendments to the Industrial Relations Bill, to provide for a special category of registration to enable professional associations, such as the B.M.A., to register without in fact becoming Trade Unions<sup>882</sup>. The Government's proposals were printed in full in the British Medical Journal<sup>883</sup>.

The G.M.S.C. held a special meeting to consider the Bill and a report prepared by the Chairman of Council's coordinating committee for submission to the Council of the Association. In his opening address Dr. Cameron made it clear that there was

a threat to "negotiation by doctors for doctors" and that he was convinced that the advantages of the various sections of the profession lay in continued unity within one organisation. The Committee considered the possibility of the autonomous committees registering separately under the proposals in the Bill and the Association becoming a confederation.\* It recommended that the Council endorse the view that no steps be taken to exclude the medical profession from the scope of the Industrial Relations Bill, that the Secretary of State and other Members of Parliament be approached to secure amendments to the Bill, and "that the proven negotiating machinery of the profession - and in particular the Local Medical Committee/Conference/General Medical Services Committee democratic organism, by which all family doctors in the National Health Service negotiate with the Health Departments and make submissions to the Review Body, must be maintained". The Committee agreed that an appropriate circular should be issued to Local Medical Committees informing them of these decisions<sup>884</sup>.

Dr. Cameron reported back to the Committee that the Council had, at its meeting on January 13, approved the following common form motion by the Chairmen of the G.M.S.C. and the Central Committee for Hospital Medical Services:-

"That in this matter the primary objectives must be the maintenance of the existing proven machinery for negotiating the terms

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\*These proposals were later found to be incompatible with the provisions of the Act.

and conditions of service, including remuneration, of doctors working in the National Health Service and the maintenance of the existing democratic procedures for formulating the policy upon which these negotiations are based".<sup>885</sup>

In its annual report to the Conference, published in April, the G.M.S.C. stressed that "irrespective of the future negotiating machinery which may be evolved, it will be essential for the independent contractor status of family doctors in contracts with Executive Councils (or their successors) to be maintained".<sup>872</sup>

The Conference approved the Committee's report, but carried, by 113 votes to 87, an amendment proposed by Dr. J.D.S. Knight of Hertfordshire:

"That this Conference recognises the importance of the B.M.A. in representing the entire medical profession and wishes to retain and strengthen the links between the Conference, G.M.S.C. and the Association, so as better to serve the interests of the family doctors in the National Health Service but believes that these aims can only be effectively achieved in the future, after the enactment of the Industrial Relations Bill, by modification of the constitution of the B.M.A. and its Council. It therefore requests the G.M.S.C. to study this matter urgently with a view to making recommendations to the B.M.A. Council." <sup>874</sup>

The annual report of the Council of the Association, prepared whilst the Bill was on the floor of the House of Lords, gave an account of the situation as it then existed and explained the

concept of a Special Register. Members were informed that the option to register had to be exercised within six months of the relevant section of the Act becoming operative, and that specific proposals would be presented to the Representative Body as soon as the Council was in a position to do so<sup>886</sup>. In July the G.M.S.C. considered the Conference resolution and also a report prepared by the Council for consideration at the Special Representative Meeting due to be held at Leicester. The Council recommended:

"That in order that the Association may continue effectively to protect the interests of the profession from the outset, the Council shall be authorised to apply for the admission of the B.M.A. to the Special Register under the Industrial Relations Act provided that such action involves no change in

- (a) the status and character of the Association, and
- (b) the existing channels of negotiation for the various branches of the profession."

The Committee considered that in order to prepare for the new situation which would arise following the enactment of the Industrial Relations Bill, when only the B.M.A. would have protection, it was essential for the structure of the Council to be revised so as to make it more truly representative. It was suggested that a certain number of members should be elected on a pro rata basis by each of the autonomous committees to make the Council more effective<sup>887</sup>.

At the Special Representative Meeting an amendment to the Council's recommendation, which would safeguard the position of the three



Defence Trusts, was proposed by Dr. Cameron and seconded by Mr. Walpole Lewin (Chairman of Central Committee for Hospital Medical Services) and Dr. Lycett (Chairman of Public Health Committee). This was carried<sup>888</sup>.

The Industrial Relations Bill received the Royal Assent on August 5 1971. The G.M.S.C. appointed a working party to consider in detail the constitutional position of the G.M.S.C. within the B.M.A. The group met several times but before it could finish its work and report the crisis over the proposed reorganisation of the Association developed.\*

The B.M.A. applied for entrance to the Special Register. The Secretary of the Association wrote to Sir Philip Rogers, Permanent Under-Secretary of State, informing him of this action and indicating that the B.M.A. intended to request that all general practitioners in the National Health Service should be recognised as a "separate bargaining unit" as defined in the Act. Hospital doctors should be treated in the same manner. The B.M.A. should then be recognised as a "sole bargaining agent" on behalf of both groups<sup>889</sup>. On December 3 the Association was entered on the Special Register and five days later Dr. Stevenson again wrote to Sir Philip formally requesting that the Department should recognise the B.M.A. as sole bargaining agent<sup>890</sup>. He replied that as the Department had always negotiated with the G.M.S.C. and the Central

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\* See next section on "The Chambers' Report".

Committee for Hospital Medical Services for general practitioners and hospital doctors respectively, these two committees had, in effect, been sole bargaining agents. The registration of the Association did not affect the situation. The Department had no proposals for change and had always considered that the representation of staff interests should be settled by the staff themselves<sup>891</sup>.\*

The legality of the enrolment of the B.M.A. on the Special Register was questioned by the M.P.U.<sup>893</sup> although it was accepted by the Solicitor General, the British Medical Association's lawyers and the Board of Trade<sup>894</sup>.

The Council proposed, and the Representative Body resolved, that Paragraph 3 of the Memorandum of the Association should be amended to read "provided that the Association shall not become or seek to become a trade union within the meaning of the Industrial Relations Act 1971 but shall be registered only in the Special Register provided for by the said Act". This amendment was submitted to an Extraordinary General Meeting of the Association<sup>895</sup> which was held immediately following the Annual Representative Meeting.

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\* These letters were of great importance - they were often quoted in the debate on the "Chambers'" proposals and were reproduced in many documents issued by the Association and the G.M.S.C., for example the Supplementary Report of the Council on the Chambers' Report<sup>892</sup>.

Dr. Hugh Faulkner, the medical secretary of the M.P.U. and a member of the B.M.A., attended the Extraordinary General Meeting and opposed the proposed changes in the Memorandum. On a poll the motion approving the changes was carried by 253 votes to 4<sup>896</sup>.

## FURTHER CHANGES IN THE GENERAL MEDICAL SERVICES COMMITTEE

### A General Medical Services Committee (Wales)

The G.M.S.C. considered the implications of the proposed devolution of health functions to the Welsh Government. Dr. Murray Jones of Caerphilly considered it of prime importance that there should be a committee which could speak directly to the Secretary of State for Wales on behalf of general practitioners in the Principality, but he emphasized that there was no desire to separate from the main Committee. It was agreed that discussions should take place with a view to establishing a Welsh General Medical Services Committee. Further discussions took place during the Autumn of 1969, when it was accepted that the new committee should be in the same relationship to the General Medical Services Committee and Local Medical Committees as the re-named Scottish General Medical Services Committee<sup>897</sup>.

The Welsh Association of Local Medical Committees proposed that the committee should include the Chairman of the G.M.S.C., the members representing Wales on the G.M.S.C., the chairman and vice-chairman of the Welsh Association of Local Medical Committees, and eleven members representing Local Medical Committees, or groups of Local Medical Committees, in Wales. In addition there should be cross representation from the Welsh Committee for Hospital Medical Services and the Welsh Regional Public Health Committee.

This constitution was approved by the parent committee in January<sup>898</sup>. The new Committee met for the first time on April 2 1970 at BMA House, Cardiff, when Drs. G. Murray Jones and W.T. Edwards were elected as chairman and vice-chairman respectively<sup>898a</sup>.

A report of the work done by the Committee was included for the first time in the report to the Annual Conference of Representatives of Local Medical Committees of 1971<sup>899</sup>.

#### Standing Orders Working Group

Following the consideration of the minutes of one of its own meetings the G.M.S.C. realised that there was a need for a reduction in the number of items included in the agenda. The General Purposes Sub-committee, invited to consider ways in which the work load of the Committee might be reduced,<sup>900</sup> prepared a short report for consideration by the main Committee and invited its Secretary to prepare a full memorandum for further consideration<sup>901</sup>.

The sub-committee pointed out that the G.M.S.C., which acted as a monthly conference of representatives of local medical committees and at the same time worked as executive of the conference, had to decide whether it wished to continue these two roles; if so it would have to accept tighter control of its procedures. The alternative would be to continue as a debating chamber and delegate more detailed business to sub-committees, or to the Secretariat under the supervision of the Chairman. The G.M.S.C.

also considered a memorandum by one of its senior members, Dr. E. Townsend of Cornwall, which criticised its methods of working. A proposition<sup>\*</sup> recommending an interim time limit on speeches of three minutes, to be followed by a review of the Committee's procedures, was carried<sup>902</sup>.

In June the Committee accepted the Secretary's report on work load<sup>903</sup>. He proposed that the General Purposes Sub-committee should meet in July after the first meeting of the G.M.S.C. to consider, and allocate to sub-committees and groups, the resolutions of the Conference and the Annual Representative Meeting, and indicate the degree of priority of each. Working groups, which should normally be short-lived, should be established consisting of up to seven members with as wide a divergence of view, experience and background, as possible. They would be expected to report to the Committee within three months or explain why. The General Purposes Sub-committee should meet monthly and keep an eye on the timetable of business, and the ad hoc meetings with the Departments and Chief Medical Officer should be replaced by a definite calendar of meetings<sup>904</sup>.

The situation continued to deteriorate; in January 1970 there were items on the agenda which had been deferred from the two previous meetings. A motion "that the time has come for this Committee to adopt formal standing orders and instruct its

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<sup>\*</sup> This proposition had been included in the Committee's agenda for February but had not been reached owing to the length of the debates on previous items on the agenda.

General Purposes Sub-committee to produce these" was carried, and a working party to study the possibilities and implications was set up under the chairmanship of Dr. W.B. Whowell<sup>905</sup>.

The group recommended that the Committee change its place of meeting from Committee Room A<sup>\*</sup> of BMA House to the Council Chamber for a trial period of three months and that a ballot should then be held to decide whether to make a permanent move. Nominations for the election of the Chairman, the Negotiating Team and the Review Body Evidence Team should take place before the first meeting of the Committee and the elections should be conducted on the "alternative vote" basis. A deputy chairman should be appointed. Membership of sub-committees, except for those of regional or special interests, should consist normally of eight members plus the Chairman of the G.M.S.C. and working groups should not exceed five members. Prior to the first meeting of the session members should be asked which of the sub-committees they would wish to serve on. Those elected to the Negotiating Team along with the chairmen of the sub-committees should comprise the General Purposes Sub-committee. The working group also produced standing orders for the conduct of meetings which included rules for debate<sup>906</sup>.

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\* Committee Room A was not large enough to seat the entire committee, and was used, as the only corridor available from one part of BMA House to another, by waitresses pushing food trolleys and many other people.



Dr. Whowell presented the group's report to the General Purposes Sub-committee,<sup>\*</sup> which opposed the suggestion that nominations should be received before the first meeting and the idea of alternative votes. It suggested that there might be two deputy chairmen, but the decision to appoint deputies, or not, should rest with the chairman. It disagreed with some of the proposed standing orders and invited the working group to reconsider its report. The working group incorporated the General Purposes Sub-committee's suggestions in its final report, and added an extra recommendation that two additional "back bench" members of the G.M.S.C. should be elected to the General Purposes Sub-committee,<sup>906a</sup> and its recommendations were adopted by the G.M.S.C.

In July 1972 the group was reconvened, in order to review its report and the standing orders in the light of the experience gained. In its second report it recommended that the membership of the General Purposes Sub-committee should be amended, to include the Negotiating Team, the Chairman of Conference, the deputy Treasurer of the Defence Trusts, and an equal number of members appointed by the G.M.S.C. Chairmen of other standing committees would have a right to attend, but not to vote. This

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\* The General Purposes Sub-committee consisted of senior members. The working group, with the exception of Dr. R.B.L. Ridge, were all relatively newcomers to the G.M.S.C.

new General Purposes Sub-committee should be empowered to take action on all matters referred to it by the G.M.S.C., the Chairman or the Secretary, implementation being delayed only when the sub-committee considered that the importance of the subject made it desirable. The working group recommended that a constitutional sub-committee should be appointed to consider the position of the G.M.S.C. and its sub-committees in relation to the B.M.A. These recommendations were accepted by the G.M.S.C., but a proposal that the two members who received the highest number of votes in the election for the Negotiating Team should be appointed as deputy chairmen was rejected<sup>907</sup>.

#### The First Deputy Chairman of the Conference

The standing orders in operation at the Conference of 1969 laid down that the Chairman should hold office from the termination of that Conference until the termination of the next following Conference<sup>908</sup>. Five candidates were nominated for election to the chair; Drs. E. Colin Russ of London, G. Cormack of Northumberland, A.A. Clerk of Dalmuir, A. Elliott of Ilford and C. Wells of Sheffield. Following a ballot Dr. A.A. Clark was elected<sup>862</sup>.

In 1971 the Conference resolved, as a reference to the G.M.S.C., that to ensure that the Chairman should command the support of a majority of the representatives the voting should be by means of serial ballots<sup>874</sup>. The G.M.S.C. reported back that this procedure was too cumbersome for such a large gathering, but the alternative vote system would be suitable. It suggested that

in view of the pressures on the Chairman and in order to allow him to vacate the chair, past chairmen of the Conference should be invited to take the chair for short periods<sup>909</sup>.

The Conference expressed a preference for the traditional method of election and, rather than call on the services of past chairmen, it would in future appoint a deputy chairman. It amended its standing orders to allow for the election and for the deputy chairman to serve on the agenda committee ex officio. Nominations were received in favour of Drs. B.L. Alexander and W.B. Whowell, and Dr. Alexander was successful in the ensuing ballot<sup>910</sup>.

#### Publicity for the work of the G.M.S.C.

In January 1967 Dr. J.S. Noble presented a paper to the G.M.S.C. on public relations. This suggested that not enough attention had been paid to the vocational image of general practice during the crisis of 1964/6, that the Committee should cooperate with the College of General Practitioners and should seek advice from public relations consultants. During the debate which followed, Dr. Noble's ideas were supported by Dr. Morgan Williams and others. Dr. Arnold Elliott, a representative of the M.P.U.,\* said that it was clear that family doctors were not getting information about the work that the Committee was trying to do on their behalf.

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\* Reports of the Committee's proceedings appeared in "Medical World", the official journal of the M.P.U.<sup>912</sup>

He complained about the reports which appeared in the Supplements to the British Medical Journal and suggested that other sections of the medical press should be allowed to report the meetings. If this was not acceptable then there should be fuller reports in the Journal. The Committee approved Dr. Noble's report and referred it to its planning group<sup>911</sup>.

In March 1970 an unsigned article appeared in "World Medicine" under the title "Carpenters and Rhubarb", describing the Special Meeting of the G.M.S.C. that had been held to consider the Todd Report and the Second Green Paper<sup>913</sup>. Dr. Cameron drew the article to the attention of the members of the Committee and reminded them that only the British Medical Journal and "Medical World" had permission to report the proceedings of the Committee, which were confidential. He did not think that any harm had been done and he was sure that, as many particulars in the article were inaccurate, no member of the Committee could be responsible.

Dr. Morgan Williams admitted that he had been responsible for the report, although he had not chosen the title. He apologised for not asking permission, being unaware that it was necessary, and explained that he had hoped to help the Committee by making its views known to its constituents. He formally asked for permission to report the Committee's proceedings in "World Medicine", which was refused. During the debate there was considerable criticism of the accounts published in the British Medical Journal and a large measure of support for Dr. Morgan Williams. However, amongst those taking the contrary view was Dr. C. Wells,

who said, "The British Medical Journal and Medical World had a responsibility to the profession which composed the membership of the bodies owning them. Other journals have no responsibility to anybody except those who financed them."<sup>914</sup>

The Editor of "World Medicine", Dr. Michael O'Donnell, wrote a leading article on the subject, repudiating the suggestion that advertisers sought to influence the policy of independent medical newspapers and journals<sup>915</sup>. The Medical Journalists Association criticised the ban on reporting and intimated that its members intended to try to circumvent it<sup>916</sup>.

Dr. O'Donnell also wrote to the Chairman of the Committee, pointing out that the remarks of Dr. Wells and others were a direct insult to him and that there were enough members of the Committee prepared to "leak" information to enable journalists to keep in touch with the Committee's affairs<sup>917</sup>. Due to pressure of business this letter was not discussed until November when the Committee "received" it. The Committee also considered a memorandum from Dr. Morgan Williams on the reporting of its meetings, which included suggestions for improving communications with the family doctors. These were carefully considered. Dr. A.A. Clark thought that information should be disseminated by members reporting back to their Local Medical Committees, and proposed that no action be taken as the Committee was satisfied with the status quo. This motion was lost by 16 votes to 18. The Committee then asked its Secretary to discuss with the Editor of the Journal the possibility that he might make a transcript of his report available to other medical publications for a charge<sup>918</sup>.

The Editor declined, as acceptance would lead the British Medical Journal to assume the role of a press agency. Furthermore, the Journal was seeking ways of economising, and if the proceedings of the Committee were widely reported "he would not feel obliged to report its debates in the same detail as now".<sup>919</sup>

It was agreed to refer the question to the General Purposes Sub-committee, and Dr. Morgan Williams was invited to the meeting. He reminded the Sub-committee that many of its constituents were poorly informed medico-politically; the importance of this fact had been obvious during the recent Review Body crisis. He suggested that, to improve matters, the Committee's reports should be made available to medical journals other than the British Medical Journal. Some members expressed doubts about the possibility of being able to persuade family doctors to take any interest in the affairs of the G.M.S.C. but the Sub-committee recommended that a working party, which would consult with experts in the field of medico-political publicity, should be established to explore the various avenues available for disseminating news of the Committee's work<sup>920</sup>.

The G.M.S.C. approved the idea\* <sup>921</sup> and the first of the group's

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\* The original selection of the G.M.S.C. was Dr. J. Marks, Chairman, Dr. Cameron ex officio and Drs. J.R. Caldwell, Morgan Williams, J.L. MacCallum, a London general practitioner with considerable journalistic experience and J. Mc A. Williams. Dr. MacCallum

five meetings was held in September. The Association's chief press officer (R.A.F. Thistlethwaite) attended the second meeting, Dr. M. Ware, the Editor of the British Medical Journal, together with Dr. G. Macpherson (assistant editor) and Mr. L. Wootton (reporter for the British Medical Journal) the third, representatives of the Medical Journalists Association (John Roper - The Times, Paul Vaughan - World Medicine and James Wilkinson - Daily Express) the fourth and the Secretary of the Association the fifth meeting.

The working group were convinced by the Medical Journalists Association's representatives and Mr. Thistlethwaite that it would be helpful, both from the point of view of keeping the general practitioners in the periphery informed and of enlightening the general public about the state of family doctoring, if the press were admitted to the Conference of Local Medical Committees. In order that such a recommendation, if endorsed by the G.M.S.C., could be included in the annual report for 1972, the group presented an interim report on this one aspect of its work to the Committee in March 1972.

The working group's idea was supported by Dr. Heath of Birmingham and others, but criticised by Drs. Ridge and Cook on the grounds

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died shortly afterwards and Dr. Mc A. Williams resigned from the G.M.S.C., his place on the working group being taken by Dr. W.M. Patterson.



that their document did not give a full account of the arguments for and against the proposition. Dr. Caldwell suggested that the Conference itself should decide whether it wished to improve its relationships with the press or not, but the Committee rejected the working group's recommendations by 22 votes to 18<sup>922</sup>. However, at the Annual Conference Dr. Heath, on behalf of the Birmingham Local Medical Committee, proposed that the press should be invited to Conferences and Special Conferences of Local Medical Committees and the motion was carried by 64 votes to 63<sup>910</sup>.

The working group recommended that there should be no change in the policy of excluding the press from meetings of the G.M.S.C. A formal press conference should only be held when matters of importance were under discussion, but there should be informal meetings with medical journalists at least once a year. The annual report should continue but the "GMS Voice" should only be issued in times of crisis and at such times consideration should be given to the buying of advertising space in the para-medical press. A special page devoted to G.M.S.C. affairs should appear in BMA News and the Editor of the British Medical Journal should be encouraged to include in the Supplement back bench opinion and signed articles based on fact.

The working group were at pains to do nothing which would interfere with the rights and duties of members of the G.M.S.C., and recommended that it would be helpful if members were coopted on to those Local Medical Committees that they represented, so that they could report directly to them. The group also recommended

that a conference of chairmen of Local Medical Committees should be held every third year and a conference of secretaries of Local Medical Committees every six years. It considered that, although it would be unwise for the G.M.S.C. to associate itself with an individual commercial undertaking, a handbook containing advertisements should be distributed by the Committee<sup>923</sup>. The report and the recommendations in it were accepted, almost without debate, in May 1972<sup>924</sup>.

THE CHAMBERS REPORT

The Annual Representative Meeting of 1970 accepted a proposition by Dr. G.E. Crawford of Liverpool "that an independent body be instructed to report to the Representative Body on a revised constitution, this to be treated as a matter of urgency". The motion was supported by Dr. C. Shiers of Council and by Dr. Lutton, Chairman of the Organisation Committee, who criticised the use of the word "body" in the motion. "By all means let us bring in outside experts" he said, "but we must be able to give the outsiders guidance." <sup>925</sup>

The following year the Council reported that Sir Paul Chambers, Chairman of the Royal Insurance Group and formerly Chairman of Imperial Chemical Industries, had accepted an invitation to undertake the task. He would work independently, but he would consult with the Chief Officers and chairmen of committees, and seek advice inside and outside the Association, taking into account the Industrial Relations Bill and the expected White Paper on National Health Service Reorganisation. He hoped to complete his work in time to present the report in person to Council and the Annual Representative Meeting of 1972<sup>926</sup>.

A motion at the Annual Representative Meeting in the name of South Staffordshire Division, "that when Sir Paul Chambers's report on the B.M.A. constitution is received, a Special Representative Meeting be called to consider it, with no other business on the agenda" was carried as a reference to Council. The Represen-

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**British Medical Association**

**Report of an Inquiry into the Association's  
Constitution and Organization**

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**SIR PAUL CHAMBERS**

Reprinted from the

**BRITISH MEDICAL JOURNAL**

BRITISH MEDICAL JOURNAL SUPPLEMENT 1972 VOLUME 2 45-67

tative Body also reaffirmed its decision of 1913, "that the Representative Body is of the opinion that no system of reorganisation of the Association can be effective which does not take into consideration the position of Local Medical Committees and devise some means of coordinating their work with that of the Association". During the debate Dr. Cameron asked that Sir Paul's attention be drawn to the potential hazards involved in reorganisation, and Dr. Gibson, Chairman of Council, also stressed that it was "terribly important" and should be "part of Sir Paul Chambers's brief"<sup>927</sup>.

#### Publication of the Report

Sir Paul's Report<sup>928</sup> was published on March 30 and printed in full in the British Medical Journal<sup>929</sup>. Sir Paul refused to produce a summary of it, insisting that it was necessary for the reader to consider all the arguments behind his conclusions.

He recommended that there should be only one democratically elected central body, the Representative Body, which would determine policy. Subordinate to it would be a small central executive and committees, all elected by the Representative Body. The autonomous committees would disappear and would be replaced by four new committees - Hospital Doctors Pay and Conditions Committee, General Practitioners Pay and Conditions Committee, Hospital Doctors Medical Services Committee and General Practitioners Medical Services Committee, each of which would have an equal number of senior and junior members.

The local organisation of the Association would consist of divisions based on National Health Service "districts" and Area Councils based on National Health Service "areas". Area Councils would be elected by members on a craft\* basis and they would elect part of the Representative Body from amongst their own members. The rest of the Representative Body would be elected by the membership as a whole, but no member of that part could be a member of an Area Council. Sir Paul emphasized that only members of the Association could hold office on any of these committees, and that there was "no obligation on the British Medical Association to provide central coordination for the work of Local Medical Committees as such".<sup>930</sup>

Sir Paul presented his report to the Council at its routine meeting in April and answered questions. Dr. Noble, deputy chairman of the Representative Body and past chairman of the Organisation Committee, noting that Sir Paul had rejected a federal structure, asked whether the trauma that might arise from the inevitable confrontation with the autonomous committees would not weaken the Association. Sir Paul insisted that federal structures were weaker in control, and had less effectiveness, than centrally controlled organisations. Dr. Cameron reminded the Council that it was his responsibility to maintain the

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\* In the report and in this thesis the expression "craft" is used to indicate the section of the profession to which the member belongs, for example general practitioner, hospital doctor, public health service doctor etc.

"L.M.C./Conference/G.M.S.C." organism; he did not think that Sir Paul had fully appreciated the full role of the Local Medical Committee, which was a body which was referred to many times in statutory instruments, and he "had a premonition that it might prove difficult to inter the sixty year old negotiating machinery for family doctors". The Council decided to hold a special meeting on July 5 to consider the views of the Standing Committees with a view to issuing a report for consideration by a Special Representative Meeting on November 15 1972<sup>931</sup>.

The national press paid considerable attention to the Report. The reorganisation, rightly described as radical by the Glasgow Herald,<sup>932</sup> would ensure that junior doctors had a greater say in the Association's affairs<sup>933</sup>. Sir Paul's view that the Association should "face realities and cooperate with the Government to make a success of the National Health Service" was received favourably<sup>934</sup>. A leading article in The Times welcomed the proposed destruction of the two autonomous committees but questioned the will of the leaders and members of the Association "to make the big adjustments necessary to equip the Association to meet the needs of today, and even more, of tomorrow".<sup>935</sup> The British Medical Journal commented favourably on the proposals to abolish the Council and the autonomous bodies, but recognised the risk that this could lead to the Association being run by professional committee men supported by the Secretariat<sup>936</sup>.

However, other journalists recognised that the proposals to destroy the G.M.S.C. would destroy the authority of the Association



and the proposal to restrict membership of committees to six years, or more for chairmen, would reduce the effectiveness of the leadership. For example, "Sequitur" (believed to be Dr. Frank Gray) wrote that "some of Sir Paul's remedies are worse than the disease"<sup>937</sup> and "World Medicine" suggested that the outside expert had unlocked the B.M.A. politicians' conscience, so that they could admit what was wrong with their Association. It suggested that the B.M.A. "should take further advice on the treatment of the malaise".<sup>938</sup>

#### Action by the G.M.S.C.

The General Purposes Sub-committee considered the Chambers Report, comments on it by Dr. Ridge, and a summary of the conclusions and recommendations prepared by the Secretary of the Sub-committee. During the debate reference was made to the assurance given by the Under-Secretary of State, in connection with the Industrial Relations Act, that the G.M.S.C. and the Central Committee for Hospital Medical Services would continue to be recognised as the sole bodies representative of all doctors in their respective branches of the profession. The Sub-committee doubted whether any committees of the Association would be so recognised if the Chambers recommendations were implemented. It was decided to seek legal advice on the position of the Defence Trusts and to consider whether the existing resources were adequate to establish, and run, a General Medical Services Committee outwith the British Medical Association<sup>939</sup>.

The G.M.S.C. was addressed by Sir Paul who also answered a series of questions from members. The Committee then debated the Report<sup>\*</sup> and the comments on it prepared by the General Purposes Sub-committee. It informed the Council that the considered view of its members, all active and experienced members of the Association, was that the adoption of the Chambers proposals would not strengthen the Association, but might well damage it irreparably, and gave its reasons for this decision. It further recommended that Council should not advise the Special Representative Meeting of November to adopt the proposed constitution, and that any future constitution must incorporate the L.M.C./Conference/G.M.S.C. structure. The Council should establish a constitution committee, representative of the major committees of the Association, to study both the Chambers Report and the views expressed upon it<sup>940</sup>.

The Council met on July 5 and considered the comments on the Chambers Report from the Standing Committees, the Board of Science and Education, the Hospital Junior Staffs Group Council and the Junior Members Forum Advisory Committee. The Organisation, Occupational Health, Private Practice and Public Health Committees, and the Northern Ireland and Scottish Councils, accepted the

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\* A "back bench comment" on the debate was written by Dr. B.L. Alexander and published in the Supplement to the Journal<sup>941</sup>. This suggested that the deputy editor had taken note of the recommendations of the Working Party on press and publicity.

principles in the Report, with varying degrees of reservation; the Hospital Junior Staffs Group Council recommended that the Report be accepted and implemented without qualification. The Central Committee for Hospital Medical Services expressed itself in favour of the principles; however the Report would have to be considered in detail by the Regional Committees before the comprehensive view of the hospital medical staffs could be made available. The Armed Forces Committee expressed its opposition to the requirement that all of its members should belong to the Association as did the Board of Science and Education, whilst the Welsh Council joined the G.M.S.C. in recommending that the Council advise the Special Representative Meeting against the adoption of the Report.

In view of this opposition the Council decided to issue its comments on the Chambers Report in two parts. The first or interim report dealt with the issues which were not opposed by any of the main committees<sup>942</sup>. Reporting on the meeting, Dr. Cameron told the G.M.S.C. that he had consented, as an individual, to serve on a small committee of chairmen which would attempt to arrive at an agreed solution to the problems. He would not be a plenipotentiary for the Committee<sup>943</sup>.

The Chairmen of the Council, the Central Committee for Hospital Medical Services, the General Medical Services Committee, Organisation Committee and Hospital Junior Staffs Group Council met and prepared a draft report for consideration by the Council. It rejected Sir Paul's proposals for reorganisation at area level

and instead recommended a scheme whereby the elections to Local Medical Committees and the Hospital Craft Organisations, both of which would have to be open to members and non-members alike, and the Area Council, restricted to members, could be undertaken in a single balloting process.

It envisaged that central craft conferences for general practitioners, hospital doctors and community physicians would continue, and a scheme was devised which would coordinate their work with that of the Representative Body. Local Medical Committees, for example, would notify the B.M.A. Area Councils of the names of their representatives to the craft conference, so that Area Councils could decide whether to elect the same representatives (if members of the Association) to the Representative Body. The allocation of motions between the Representative Body and the Conferences would be carried out by a joint agenda committee appointed by the separate organisations. The report suggested that there should be a review of the composition and mode of election of the three main committees in consultation with the committees concerned and that the possibility that they might be elected by the craft conferences should be considered. The exchange of letters between Dr. Stevenson and Sir Philip Rogers concerning the Association and the Industrial Relations Act, and details of the proposals for elections, were reproduced as an appendix to the report<sup>944</sup>.

The General Purposes Sub-committee of the G.M.S.C. considered the draft report of the Committee of Chairmen and produced a commentary

on it. It recommended that the G.M.S.C. should consider the commentary "in committee" to overcome the procedural problems implicit when a Council document was debated prior to Council's receipt of it<sup>945</sup>. During the G.M.S.C.'s meeting on August 24, the Committee converted itself into "an augmented General Purposes Sub-committee". This did not favour any suggestion that Local Medical Committee elections should be conducted centrally but supported the proposals for bringing the conferences and the Representative Body together and for the establishment of a joint agenda committee. The Council of the Association approved the draft report with minor modifications, by 26 votes to 7\* for presentation to the Special Representative Meeting<sup>946</sup>.

The G.M.S.C. decided to present a report on the proposed constitution to the Special Conference which had already been convened to consider the White Paper on National Health Service Reorganisation. During the debate the Committee was reminded by its Secretary that "the whole purpose of the exercise was not to preserve the sanctity of the Local Medical Committee but rather to promote the best interests of the doctors for whom the Local Medical Committee existed to serve".<sup>947</sup>

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\* Drs. Appleyard, Beaton, Crawford, Lawrence, Leaming, Shiers and Watts formally requested that their names be recorded as voting against the motion.

The Conference rejects Chambers

The report of the G.M.S.C. included four recommendations on the Chambers Report:-

Recommendation I - that this conference reiterates its policy that there must be no alteration in the existing L.M.C./Conference/G.M.S.C. structure;

Recommendation II - that the proposals of the British Medical Association Council for coordinating the electoral machinery of area craft committees and British Medical Association area councils should receive further detailed consideration, exploring the possibility of arranging separate simultaneous elections;

Recommendation III - that the proposals for coordinating the work of the craft conferences with that of the Representative Body of the Association be adopted in principle;

Recommendation IV - that support be given to the recommendation of the Council that, in consultation with the committees concerned, a review of the constitution and mode of election of the central craft committees be undertaken; the majority of members of the G.M.S. Committee must however continue to be directly elected representatives of L.M.C.'s or grouped L.M.C.'s. <sup>948</sup>

Only seventeen motions and amendments were received from Local Medical Committees concerning the Chambers Report, whereas over one hundred were received on National Health Service reorganisation <sup>949</sup>. The agenda committee recommended that the part of the agenda relating to the Chambers Report should be dealt with, as far as possible, between 2 p.m. and 3.15 p.m. <sup>950</sup>

An amendment by Worcestershire Local Medical Committee, "that any motion to rescind or change existing policy of the Conference relating to the constitution and/or organisation of the L.M.C./Conference/G.M.S.C. structure or which materially affects the G.M.S. and National Insurance Defence Trust Funds shall require not less than a two thirds majority of the votes given to be deemed an effective decision of the Conference", was carried.

After Dr. Cameron had outlined the reasons for the Committee's recommendations the main debate took place on an amendment from Stirling and Clackmannan recommending the adoption of the Chambers Report, which was defeated. Dr. Cameron then moved the adoption of Recommendation I which was opposed by Dr. Lutton who expressed the view that the Conference had no legal standing and was simply a debating chamber. Dr. Marks said that Dr. Lutton was correct, but the G.M.S.C. could only ignore the decisions of the Conference at its peril. The recommendation, finally amended to read "that this Conference reiterates its policy that there must be no alteration in the principle of L.M.C./Conference/G.M.S.C. structure" was carried by a large majority. The word "principle" became very important throughout the Chambers controversy.

A motion by Dr. Harris of Huntingdon and Peterborough "that in the event of the Representative Body rejecting its Council's advice to retain the existing autonomous committee structure and L.M.C./Conference structure independent of the British Medical Association must be established" was opposed by members of the G.M.S.C., who felt that it would be considered as a threat by the Representative



Body, which was due to meet the following week. Following an assurance from Dr. Cameron that, should the unhappy situation referred to in the motion come about, another conference would be called, the motion was withdrawn. The Conference then accepted Recommendations II, III and IV without debate.

After a full consideration of the G.M.S.C.'s report on National Health Service Reorganisation the Conference continued its debate on the Chambers Report; but when only one item had been considered a count showed that there was not a quorum present, and the Chairman adjourned the meeting<sup>852</sup>.

The Special Representative Meeting of November 5 1972<sup>951</sup>

In an interview which appeared in "Pulse" between the Special Conference and the Special Representative Meeting Dr. Clifford Lutton "passionately endorsed" the Chambers Report which he described as a "package deal". He insisted that "compromise on Chambers is difficult and dangerous".<sup>952</sup>

The agenda committee had a difficult task arranging the order of business; normally all debates at Representative Meetings take place on motions and amendments relating to a report of Council, but the members of the agenda committee believed that the Representative Body wished to consider the Chambers Report itself. A motion sent in by Birmingham division "that this meeting debates and votes on the acceptance or rejection of Sir Paul Chambers's Report, in principle, before debating Council's report", supported this view. A further complication arose because only

members of the Representative Body, or in special circumstances members of the Association, may address it, but Sir Paul Chambers had expressed the wish to present his Report to the meeting in person.

At the Special Representative Meeting the Chairman indicated that he was prepared to accept the Birmingham motion, because the agenda had been arranged on the assumption that he would do so. He proposed "that Sir Paul be invited to address the meeting" and then "that the meeting go into committee to hear him".

Sir Paul addressed the meeting for forty minutes explaining that the major differences between his proposals and those of the Council arose from a "fundamental difference of mind". He defended his proposals to abolish autonomy and exclude non-members from the Association's activities. To laughter and applause he attacked the autonomous bodies' reliance on Sir Philip Rogers's views on the negotiating machinery for hospital doctors and general practitioners. Sir Paul insisted that the Department would be prepared to continue to accept the B.M.A. committees composed only of members as representing the Association and therefore the profession. He acknowledged that his assumption that B.M.A. Area Councils would be accepted as medical advisory bodies, considered by many as the keystone to his proposals, was invalid. He also agreed that his arbitrary division between young doctors and others of 35 years of age could be wrong.

Sir Paul concluded: "Having read and heard much since I handed in my Report on the 31st March I stand by my proposals. I recommend

the acceptance of Resolution 15 which proposes that the Chambers Report be accepted in its entirety. The minor modifications which I have suggested to the proposals in my Report are not fundamental and can be dealt with in drafting the new constitution. They are not inconsistent with the vote to accept the Report in toto."

The B.M.A. agenda has no "resolutions", only motions and amendments and riders. Motion 15, marked as a priority motion by the agenda committee "That this meeting believes that the B.M.A. should accept the Chambers Report in its entirety" was proposed by Dr. G.H. Shepherd of Gloucester. After a debate lasting for two hours, and in spite of opposition from the Chairmen of Council and the main committees, it was passed by 153 votes to 149. This was less than the two thirds majority necessary to change the Association's policy. Dr. R.A.R. Lawrence, deputy chairman of the Organisation Committee and the representative of Derby division then proposed "that this meeting accepts the Chambers Report in principle".

The motion was opposed on the procedural grounds that it did not differ from the previous one, but a motion that the meeting "pass the next business" was not carried by the three quarters majority required by the standing orders. Other speakers then opposed it on the grounds that "in principle" meant different things to different people but Dr. Mitchell of Somerset defined the principle of Chambers "as being a unified structure in which only B.M.A. members should be allowed to take part in B.M.A. standing committees and negotiating machinery".



Dr. Lawrence in his reply to the debate exhorted the Representative Body, "Let not your emotional prejudices bedevil your judgement today". But after the motion had been carried by 217 votes to 92, a decisive two thirds majority, the atmosphere resembled a "revivalist meeting".<sup>953</sup>

The Chairman adjourned the meeting so that the agenda committee, in consultation with the Chairman of Council, could consider the effect of this decision upon the remainder of the business. At the resumption the Chairman of Council accepted that the Representative Body had interpreted "in principle" to mean the abolition of autonomy and the exclusion of non-members. He proposed that the Council be instructed to prepare a further report and the necessary changes in the Articles and Bye-laws and to report to the Representative Body in due course. Following the acceptance of this motion the meeting terminated at 3.50 p.m.

#### First reactions to the Representative Body's decision

Council met ten minutes later and immediately went into camera. After some discussion it was proposed by Dr. Lawrence and seconded by Dr. Crawford that "the matter be referred to the Organisation Committee for consideration and report". Subsequently it was proposed by Dr. G.E. Maloney "that the R.B.'s decision be referred to the Standing Committees and certain aspects of the Chambers Report to a special working party set up for the purpose, for consideration of the Report, and that the Chairman of Council's Coordinating Committee be asked to submit a fundamental report to Council as soon as possible". At this stage

the Chairman indicated that if the Council wished to reach a firm decision on the lines of either of these motions it should suspend Standing Order 2, which required the issue of an agenda seven days before a Council meeting. A motion to suspend standing orders was carried, Dr. Lawrence's motion was lost, and Dr. Maloney's was carried. The Chairman asked the Council to determine the composition of the working party at its meeting on November 22.<sup>954</sup>

The routine November meeting of the G.M.S.C. took place on the day after the Special Representative and Council meetings<sup>955</sup>.

Dr. Cameron gave an account of the events of the previous day, and expressed his opinion that the alternative proposals of the Council and G.M.S.C. had not been understood because they were too sophisticated; the profession as a whole did not fully appreciate the position of the autonomous committees, or the implications of the independent contractor status on which the Local Medical Committee structure was based.

Dr. Ridge placed the conflict in an historical perspective, explaining how B.M.A. divisions had gradually lost their political power to the Local Medical Committees and, more recently, had lost some of their educational and scientific functions to the post-graduate medical centres. He considered that the clash between the Conference and the Representative Body had been inevitable and suggested that the Committee should set down on paper the essential nature of and the necessity for autonomy. It should then recommend to the Conference that the thesis should be put to the

test of a plebiscite amongst practitioners. They should be invited to decide the method by which they preferred to be represented. If the Committee's recommendations were supported, then the B.M.A. should be asked to provide an appropriate "executive machinery"; should it not agree to do so then the representatives of the general practitioners would have no alternative but to provide their own body.

Dr. J.H. Marks suggested that there were four alternative courses of action open to the G.M.S.C.; to attempt to reverse the decision of the Special Representative Meeting; to accept the Chambers Report in principle; to advise Local Medical Committees and the Conference to set up a new structure, which would have to be a registered trade union, or to attach Local Medical Committees and the Conference to an existing trade union.

The Secretary of the Association believed that there were only two courses open to the Committee; to persuade the Representative Body to change its policy or to go it alone. He felt that the latter course would be most unfortunate for all concerned. He expressed reservations about the Committee holding its own plebiscite and suggested that the Council might be asked to conduct a plebiscite of the whole profession.

Many speakers emphasized the need to retain the relationship between the G.M.S.C. and the Association, and that all possible steps should be taken to heal the breach. Dr. Noble, Chairman of the Representative Body, said that "he understood at the time

the Chambers Report was being discussed that the General Medical Services Committee was tending more to react than to explain. If it felt that the message had not been got across now was the time to see to it". The G.M.S.C. agreed to report to a special conference when a report on the matter had been prepared, and the General Purposes Sub-committee was instructed to draw up a draft report.

At its routine November meeting most of the Council's time was occupied in considering the deteriorating situation within the profession created by the General Medical Council's declared intention to erase doctors who had not paid their retention fee, and the meeting ended earlier than usual because of an impending rail strike. The Chairman reported that, because of the pressure of events, it had not been possible to put to the Council the suggested membership of the working party which would consider a new constitution of the Association. He undertook to send the names to members as soon as possible<sup>956</sup>.

#### Preparations for a Special Conference

The General Purposes Sub-committee met on November 23 to debate the problem and to consider papers prepared by Drs. J.H. Marks, D.L. Williams and R.B.L. Ridge. It agreed that any attempt to alter the Special Representative Meeting's decision by galvanising B.M.A. divisions was unlikely to succeed, and that it would be more valuable to undertake a plebiscite of all general practitioners in the National Health Service on the authority of the Conference.



The results could then be presented to Council and through it to the Representative Body.

The Sub-committee also accepted the proposal contained in Dr. Ridge's paper that Conference should be asked to authorise the General Medical Services Committee to repeat the invitation it made sixty years ago to the B.M.A. to provide within its constitution for a permanent committee which could act as the executive of the Conference.\* In the Sub-committee's view if such an invitation was refused immediate steps would have to be taken to establish an independent organisation representative of all National Health Service general practitioners. This it considered would be to the disadvantage of both the B.M.A. and general practitioners, because the profession would thereby be split into a number of groups none of which would be large enough to be able to claim sole negotiating rights. A joint negotiating panel on the lines of that operating in the teaching profession would probably be the outcome - and the likelihood of such a body ever negotiating with the authority and success of the G.M.S.C. of the B.M.A. was remote.

Furthermore problems would arise with regard to the Industrial Relations Act. Whatever organisation was set up would have to

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\* The Sub-committee did not realise that the original representatives to the Insurance Acts Committee were elected by the Conference from amongst its own members and were not directly elected by Local Medical Committees.

fulfil the requirements of the Act in order to register and enjoy protection in the event of action taken in an industrial dispute.

The Sub-committee then discussed the financial implications of a break from the B.M.A.; the position of the G.M.S. Defence Trust; the necessity for general practitioners to contribute to the new organisation; and the possibility of having to establish an "agency shop". The Sub-committee agreed that these matters should be brought to the attention of the periphery.

The Sub-committee decided that a draft report to Conference based on Dr. Ridge's paper should be prepared by the Secretary of the Sub-committee for consideration by the G.M.S.C. at a special meeting on December 7, and that a Special Conference should be held on February 14<sup>1957</sup>.

#### Three committees with different views

The General Medical Services Committee, the Central Committee for Hospital Medical Services and the Organisation Committee all met in BMA House on Thursday, December 7.\*

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\* Due to a shortage of staff no official reporter from the Journal was present at the meeting of the G.M.S.C., but a report appeared in "Medical World". Page 1 of that journal had the headline "This issue contains the exclusive official report of the G.M.S.C. meeting on December 8", while page 5 refers correctly to the meeting of Thursday, December 7.<sup>958</sup> The British Medical Journal,

The C.C.H.M.S. devoted the afternoon to a discussion of the Special Representative Meeting and of the events which followed it. Dr. Myre Sim made a strong plea for the Committee to accept and act on the Special Representative Meeting's decision without equivocation or delay. He was supported by Drs. Leeming and D.E. Bolt, but Mr. A.H. Grabham said that he was concerned about the working of the Chambers proposals. He could not see how the Representative Body, meeting once a year, could effectively direct the Association, nor how a committee containing only six of their representatives could carry out the work necessary to protect the interests of all hospital doctors. The Committee instructed its Executive Committee to prepare a report for discussion at a special meeting of the Committee. By a small majority it was decided not to call a National Hospitals Staff Conference but members were asked to take the widest possible sounding of opinion in their regions before the January meeting so that the decisions which were reached then would be as democratically based as it was possible to be<sup>960</sup>.

The Organisation Committee under its chairman Dr. Clifford Lutton discussed the Special Representative Meeting's decisions too, and concluded that the Chambers Report contained nineteen fundamental principles, including the abolition of the two autonomous bodies,

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giving a summary of the Committee's report to the Special Conference referred incorrectly to "the meeting of December 6" <sup>959</sup>.

the Junior Hospital Staffs Group Council, and the Junior Members Forum. All committees were to be small working bodies of members elected by the Representative Body from amongst its own members, who would only be allowed to serve for six years<sup>961</sup>. The G.M.S.C. "received" a letter from the South West London and Surrey Local Medical Committee asking the G.M.S.C. to cooperate in every way with the B.M.A. to ensure the continuity of effective representation of general medical practitioners within the B.M.A.\* It considered the draft report prepared by the Secretary,<sup>962</sup> written comments from members on the draft report, and letters from the Welsh Association of Local Medical Committees and the Denbighshire and Flint Local Medical Committee, who deplored the action of the B.M.A.

Opening the debate the Chairman denied that the G.M.S.C. was indulging in "brinkmanship", because he believed that the decision facing the Committee was probably the most critical one it would ever be called upon to make. Dr. Ridge recalled Sir Paul's address. In his (Dr. Ridge's) view the point of issue was whether the terms of service and remuneration of general practitioners were exclusively the Association's affair. He reminded members of the Committee's policy on autonomy and the exclusion of non-members

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\*The Chairman of the South West London and Surrey Local Medical Committee was Dr. J.C. Cameron, Chairman of the G.M.S.C.; the acting chairman was Dr. Gethen, Chairman of the Conference of Local Medical Committees.

and of the fact that members of the M.P.U. and the Medical Women's Federation served on the Committee. Dr. R.A. Keable-Elliott was equally firm in the view that the strength of the G.M.S.C. lay in the fact that it was regarded by the Government as the voice of general practice because it was representative of one hundred per cent of general practitioners. Once it ceased to be so its strength would diminish. The B.M.A., on the other hand, had a valuable part to play as a coordinating body collecting and correlating the views of the profession as a whole.

Referring to the financial position of the G.M.S.C., Dr. W.G.A. Riddle, deputy treasurer of the Defence Trusts, reported that if Local Medical Committees continued to contribute their quotas to the G.M.S. Defence Trust an independent "General Medical Services Committee" would be financially viable. On the other hand Dr. J.H. Marks considered that an independent G.M.S.C. would not be viable and that the Committee had been less than honest with Local Medical Committees in allowing them to believe that it would be. A legal opinion sought by the Working Group on the Industrial Relations Act had stated that an independent G.M.S.C. would not be registrable under the Industrial Relations Act; therefore even if it were possible to establish an independent union it would, in Dr. Marks's view, have to become part of a larger unit, sooner or later. Dr. B.L. Alexander made the point that as Local Medical Committees were going to continue they would want to form an association and hold a conference. An executive of that conference would necessarily be set up - and the Committee must attempt to ensure that this structure remained within the B.M.A.

The Committee then debated the recommendations in the draft report. It was agreed that additional paragraphs should be included referring to the decision of the Representative Body in 1971 concerning the relationship between the work of the B.M.A. and the Local Medical Committee and the position of the G.M.S.C. vis-à-vis the Industrial Relations Act. A footnote was included which read:-

"Under the provisions of the Industrial Relations Act 1971 as they now stand protection under civil and criminal law is conferred only upon registered organisations (either of workers or of employers). It is clear from S.84(2) that no organisation formed after the passing of the act can (like the B.M.A.) be admitted to the Special Register. Any such new organisation would have therefore to seek admission to the ordinary Register, i.e. seek to become a "trade union" within the meaning of the Act (S.61.(3))."

The recommendations, as amended, were:

1. That it be reaffirmed that the system of representation of National Health Service general practitioners should continue in principle to consist of an L.M.C./Conference/G.M.S.C. structure;
2. that this Conference requests the General Medical Services Committee to repeat the invitation of 60 years ago to the British Medical Association to provide for the structure to remain within its constitution;
3. that this Conference considers that in the event of such invitation being refused, steps be taken to establish an independent organisation representative of all N.H.S. general practitioners;

4. that following this Conference all N.H.S. general practitioners be invited by postal referendum to record their views. <sup>963</sup>

The first recommendation was accepted by the Committee unanimously and there were two abstentions in the voting on the third and fourth. The second recommendation was opposed by the two M.P.U.'s representatives because the Union had always been in favour of autonomy for the G.M.S.C., and held that the special association of the Committee with the B.M.A. was an anomalous one <sup>958</sup>. The report of the G.M.S.C. to the Special Conference, Document SC.12, was entitled "How are N.H.S. Family Doctors to be represented?". It was sent to all family doctors and copies were made available to members of the Council and Local Medical Committees. Included in an appendix were a short account of the constitution of the Committee, its terms of reference, a list of its sub-committees and of the bodies on which it was represented. The Document pointed out that "although the G.M.S.C. is a Standing Committee of the B.M.A. about 80% of the cost of the many activities outlined are not a charge on B.M.A. funds. They are paid for very largely by the General Medical Services Defence Trust, to which all L.M.C.'s contribute, and from the N.I.D.T. fund which was built up in the years 1919-1948". <sup>964</sup>

The General Purposes Sub-committee met on December 13 and considered what action needed to be taken to publicise the views of the parent Committee on the representation of National Health Service general medical practitioners. A small chairmen's sub-committee was set up consisting of the Negotiating Team and



two other members of the G.M.S.C., with authority to seek such expert advice as was necessary. Some discussion took place on the position of the Secretariat in servicing this proposed sub-committee, and also on the venue for its meetings. It was agreed that these were matters which should be kept under review<sup>965</sup>. The Chairmen's Sub-committee met twice in BMA House.

The appointment of the Working Party and the proposed referendum<sup>966</sup>

Before the Council meeting of December 20 the names of the proposed members of the Working Party which would prepare a draft scheme for the reconstitution of the Association were circulated. In addition to himself the Chairman of Council suggested the Chairman of the Representative Body, the Treasurer, and Drs. Lutton, Lycett, McCrae, C.J. Wells, Wright and Myles Gibson. Dr. Wells indicated that he was unable to serve, and the Chairman of the G.M.S.C. was asked to consult his Committee about a replacement. It was agreed that the Working Party should be composed solely of members of Council, on the understanding that "members of Council" included chairmen of Standing Committees entitled to attend Council meetings.\*

A proposal from the Organisation Committee, that a questionnaire on the Chambers proposals should be circulated to the profession

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\* Dr. Lutton, Chairman of the Organisation Committee, who was not a member of Council was the only member of the Working Party in this category.

after the Working Party had reported, was debated at length.

After Dr. Cameron had outlined the G.M.S.C.'s views and drawn the members' attention to Document SC.12, Dr. Leaming pointed out that the G.M.S.C. had published this Document under the heading "British Medical Association" although it included views which were contrary to the policy of the Representative Body. Other members reminded the Council that the G.M.S.C. would have been criticised if it had departed from its normal practice of issuing documents under this heading and furthermore it was doing the job that the Council had asked it to do, namely to obtain the views of its constituents. An amendment to hold a plebiscite amongst members and non-members was defeated, and it was finally decided to leave the proposal for a questionnaire "on the table".

The matter did not rest however. When Dr. Cameron presented to the Council a report on the meetings of the G.M.S.C. held on November 16 and December 2, which included Document SC.12 as an appendix, Dr. Leaming proposed that a paragraph in the report dealing with the Chambers Report be referred back to the Committee. He was supported by Dr. Appleyard. Mr. Walpole Lewin reminded the Council that it was merely receiving a progress report from the G.M.S.C., the object of which was to keep the Council informed of the Committee's activities. Dr. Cameron offered to withdraw the report but Dr. Lutton suggested that the Council was running away from reality. The report of the G.M.S.C., excluding the item dealing with the Chambers Report - which was received - was approved.

The following day the Chairman informed the G.M.S.C. of the Council's decisions and that Dr. A.A. Clark<sup>\*</sup> had agreed to serve on the Working Party if it were the wish of a large majority of the G.M.S.C. Members of the Committee who were also members of the Council, but who were opposed to the Chambers Report, supported the action of the Council in appointing a Working Party to consider the constitution, because it was its duty to carry out the Representative Body's instructions. Dr. Noble, Chairman of the Representative Body, told the Committee that if it was intent on staying in the B.M.A. it was essential that it participate in the Council's Working Party. Dr. Ben Ridge proposed "that whilst the General Medical Services Committee is in the process of consulting its constituents with a view to advising Council on the implementation of Chambers in principle, it is premature to take steps towards that end. It would therefore be illogical to nominate a member of the G.M.S.C. to serve on the Council's Working Party". This was seconded by Dr. D.I.T. Wilson. After a lengthy debate a proposal to pass to the next business was defeated

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\* Dr. Clark was deputy chairman of the Representative Body, a member of the Council and of the G.M.S.C. He was the immediate past chairman of both of the Scottish G.M.S.C. and of the Conference of Representatives of Local Medical Committees at the time when Sir Paul was preparing his evidence. He subsequently expressed the view that the Conference had been insulted because Sir Paul had not invited him to give evidence<sup>967</sup>.

by 23 votes to 20 and Dr. Ridge's motion was then defeated by 31 votes to 16.

The next business, a motion by Dr. J.R. Caldwell "that the General Medical Services Committee is unwilling to nominate a member to the Working Party" was also lost, whereupon Dr. R.A. Keable-Elliott proposed that a representative be appointed to serve on the Working Party. This was carried and a proposal that Dr. Alastair Clark should be nominated was carried by a very large majority<sup>968</sup>.

#### Activities in the periphery

Between the Special Representative Meeting in November and the Special Conference of February 14 a lively correspondence developed in the British Medical Journal and elsewhere. Dr. Crowe, chairman of the Junior Members Forum and member of Council, blamed the agenda committee for the Representative Body's nebulous directive to implement the Chambers Report in principle. In his view the Council's recommendations should have been considered section by section as amendments to the Chambers Report<sup>969</sup>. Dr. Alfred Reeves, a long standing member of the Representative Body and of the G.M.S.C., expressed his disgust at the undignified foot-stamping which had prevented Dr. Cameron and Mr. Walpole Lewin from developing their argument at the Special Representative Meeting and revealed that one member of the Representative Body had asked him, after the vote, "What is a Local Medical Committee?"<sup>970</sup> A consultant psychiatrist, Dr. Harry Jacobs<sup>971</sup> who had also been present at the Special Representative Meeting, criticised the proposed election of negotiators by a "jamboree", and interviews

conducted by World Medicine suggested that many of the B.M.A.'s members who had argued for the acceptance of the Chambers proposals with evangelic zeal had little notion of what those proposals really meant<sup>972</sup>.

Denbighshire and Flint Local Medical Committee called on all members of the B.M.A. to repudiate the divisive action of the Representative Body<sup>973</sup> while Dr. Murray Jones, Chairman of the G.M.S.C. (Wales), attacked both the Representative Body's decision and that of the G.M.S.C. to appoint a member of the Working Party<sup>974</sup>. Writing under the pseudonym of "Dr. James Douglas" a general practitioner in South East England expressed the view that the G.M.S.C. and Local Medical Committee structure must be retained even without the help of the B.M.A.<sup>975</sup> and that the proposal to disenfranchise 30% of general practitioners was arrogant and unacceptable<sup>976</sup>.

Support for the Representative Body was received from the British Medical Students Association who feared that the leaders of the profession did not realise that medical treatment was dependent, not on individual doctors and crafts, but on teams. "In ten years time the autonomy, not of the General Medical Services Committee and the Central Committee for Hospital Medical Services but of the British Medical Association itself will be in question"<sup>977</sup>.

Dr. Ronald Gibson, former Chairman of Council, could find no excuse for the G.M.S.C.'s recommendation<sup>978</sup> and Dr. Myre Sim felt that those members of Council who opposed Chambers in principle should resign<sup>979</sup>.

At the suggestion of Dr. Ridge, Dr. Cameron sent a postcard to all general practitioners in the National Health Service drawing their attention to the G.M.S.C.'s report, asking them to discuss the matter with their colleagues, and to do their utmost to attend any meetings that were called in their areas<sup>980</sup>. This provoked a vigorous attack by Dr. Ivor Jones who accused Dr. Cameron of making an error of political judgement "in chagrin, disappointment and anger that the profession rejected his advocacy - Document SC.12 is likely to go down into history with the ignominy previously reserved for an earlier General Medical Services Committee Document SC.7".<sup>981</sup>

Dr. Dermot Lynch, Secretary of the South Middlesex Division of the B.M.A., accused the G.M.S.C. of throwing down the gauntlet, and urged members of the Association to put pressure on their Local Medical Committee representatives to accept the Chambers proposals, to attend open meetings, and to vote against the G.M.S.C.'s recommendations<sup>982</sup>. The Middlesex Local Medical Committee, of which Dr. Lynch was a member, held such an open meeting on January 14<sup>982a</sup>. In spite of a well reasoned speech by Dr. Lynch, the doctors present accepted the G.M.S.C.'s four proposals by an overwhelming majority. A proposal from the floor recommending that members of the B.M.A. be invited to resign from the Association was opposed by Dr. Ridge, Chairman of the Middlesex Local Medical Committee, and was defeated.

The Hertfordshire Local Medical Committee called an open meeting on January 16 which was attended by 54 general practitioners, six

# British Medical Association

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## A REPORT OF THE GENERAL MEDICAL SERVICES COMMITTEE

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### HOW ARE N.H.S. FAMILY DOCTORS TO BE REPRESENTED?

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PLEASE READ THIS REPORT, AND KEEP IT AFTERWARDS.

IT IS ABOUT A MATTER OF GREAT IMPORTANCE TO  
GENERAL PRACTICE: NAMELY, THE PROPOSALS, IMPLIED IN  
RECENT DECISIONS OF THE BRITISH MEDICAL ASSOCIATION,  
TO ABOLISH THE PRESENT ARRANGEMENTS  
FOR LOOKING AFTER YOUR INTERESTS AS A FAMILY DOCTOR  
IN THE NATIONAL HEALTH SERVICE.

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A Report to the Special Conference of Representatives of Local Medical Committees  
on Wednesday, 14th February, 1973.

#### To All N.H.S. General Practitioners

#### "How are N.H.S. Family Doctors To Be Represented?"

The G.M.S. Committee sent you this Report a few days ago. It reminds you how the membership of the Committee is based upon all N.H.S. general practitioners, through their local medical committees. With this authority the G.M.S.C. is able to look after your interests, including, of course, the money you are paid for the work which you do.

Please study this Report and keep it by you. Discuss it with your colleagues — and do your utmost to attend any meetings called in your area.

The representatives of all local medical committees will attend a Conference here on 14 February, to make decisions on the recommendations set out in the Report. Then the G.M.S. Committee will be able to tell the Council of the Association how family doctors do wish to be represented in the future.

We need your support.

JAMES CAMERON,  
*Chairman, General Medical Services Committee*  
B.M.A. House, Tavistock Square, London WC1H 9JP

P.S. If by mischance you have not received the Report, or mislaid it, please let me know.



of whom were not members of the B.M.A. The meeting supported recommendations one and two almost unanimously, and suggested an amendment to recommendation three. The next day the Local Medical Committee ratified these decisions and submitted two motions for the agenda of the Special Conference:-

1. "That this Conference urges all general practitioner members of the B.M.A. to attend the meetings of their division which will consider the Annual Report of the Council in order to persuade every division to submit a motion to the Annual Representative Meeting insisting that the L.M.C./Conference structure be retained within the Association."
2. "That Conference instructs the G.M.S.C. to work out with the Council of the B.M.A. a scheme of representation of general practitioners to Government which is compatible with 'Chambers in principle' and Conference policy."<sup>983</sup>

The Inner London Local Medical Committee supported all of the G.M.S.C.'s recommendations except the proposal for a postal referendum; Birmingham Local Medical Committee rejected the idea of an independent organisation of National Health Service general practitioners and Ipswich Local Medical Committee supported the Chambers proposals<sup>984</sup>. Experienced medical journalists made estimates of the number of members who would leave the B.M.A. if the G.M.S.C. were destroyed, varying from 5000 to 10,000 or more, and commented on the risks to the profession inherent in this possibility<sup>985, 986</sup>. The Junior Hospital Doctors Association, which opposed the B.M.A. on many issues, realised that the "vicious infighting" could only weaken the Body which claimed to

represent every section of the medical profession<sup>987</sup>.

Even at this stage the need to consider a compromise solution was being put forward by Drs. Keable-Elliott and Mervyn Goodman of the G.M.S.C. and others<sup>988, 989, 990</sup>. The Chairman of the Huntingdon and Peterborough Local Medical Committee revealed that 63 out of 67 members of the B.M.A. who responded to a questionnaire were anxious to avoid a confrontation<sup>991</sup>.

At a special meeting of the Huntingdon and Peterborough division of the B.M.A. it was resolved "that the proposal passed at the last Special Representative Meeting to agree to Chambers in principle be rescinded in order that the recommendations of Council to that meeting, which were on the agenda but were not discussed, should receive proper and deliberate consideration". The secretary of the division asked the secretaries of other divisions to contact him with a view to giving support<sup>992</sup>. The annual general meeting of the Finchley division of the B.M.A. made a similar request to the Council<sup>993</sup>.

#### The Central Committee for Hospital Medical Services changes its mind

The C.C.H.M.S. held a special meeting on January 4 to discuss the Chambers Report. Its executive sub-committee had prepared a report on the possible representation of hospital doctors in a British Medical Association reorganised on the lines of the Chambers proposals, which was to be sent to the Regional Committees for consideration. The Committee decided not to include in its

report the executive sub-committee's draft recommendation that the Chambers Report be accepted in principle and it referred the question of junior representation to the Hospital Junior Staffs Group Council<sup>994</sup>.

The Regional Committees were asked to answer the following questions:-

1. Is it acceptable that the representation of hospital doctors within the British Medical Association should be limited to the members of the British Medical Association and that the central committee representing them should lose its autonomous powers as recommended by Chambers?  
and
2. Does the framework set out in the Central Committee for Hospital Medical Services' report provide a satisfactory solution to acceptance of Chambers "in principle" and if not, what amendments should be made to the Central Committee for Hospital Medical Services' report?

At the next meeting of the Committee Dr. Astley reported that out of seventeen Regional Committees which had replied, ten had said "no" to the first question and eleven had replied "no" to the second. In Dr. Astley's view it would seem that there was no majority support for Chambers in the regional committees. After the known protagonists of Chambers such as Drs. Leaming and Sim had produced their usual arguments, Mr. A.H. Grabham, first deputy chairman, moved "that the Central Committee for Hospital Medical Services after further examination and debate and further

consultation with the regional committees believes that the Chambers proposals do not provide an acceptable constitution to represent the interests of hospital doctors and should not therefore be implemented". The motion was seconded by Mr. Myles Gibson, second deputy chairman, and was carried by 43 votes to 12<sup>995</sup>.

This decision was conveyed to the Council and to the [second annual] National Conference of Hospital Medical Staffs<sup>996</sup> at which Dr. Myre Sim attempted to suspend standing orders in order that a Birmingham Region motion endorsing the decisions of the Special Representative Meeting could be considered. He failed and the Conference endorsed the policy of the C.C.H.M.S.<sup>997</sup>

#### Autonomy becomes delegated responsibility <sup>998</sup>

The Stirling and Clackmannan Local Medical Committee requested the G.M.S.C. to invite Sir Paul Chambers to address the special committee in order to outline the advantages of his proposal. Dr. Morgan Williams pointed out that the point of issue was not the Chambers Report itself, but the decision of the Special Representative Meeting to adopt it in principle. The Committee resolved that Sir Paul Chambers should not be invited to attend the Special Conference<sup>999</sup>.

The Special Conference opened with a procedural wrangle. To the motion "that the report of the agenda committee be approved", Dr. Harris of Huntingdon and Peterborough proposed that, because the first recommendation was merely a re-statement of established policy it should be treated as an "A" ("accepted") motion and voted upon without debate. This was opposed by Dr. Metcalfe of

Ipswich, whose Local Medical Committee supported the Representative Body, but was carried. Dr. Gethen, the Chairman of the Conference, pointed out that as a result of that decision several other amendments would not be debated. Dr. Morgan Williams of the agenda committee suggested that the situation was one of potential disaster, and that the Conference was in danger of making the same mistake as that made by the Special Representative Meeting by taking a policy decision on a procedural motion. He moved the suspension of standing orders so that the first recommendation and the subsequent amendments could be debated. He was supported by Dr. K.A. Wood of the G.M.S.C. and Dr. Cameron. The motion to suspend standing orders was carried by the necessary majority and the amendment in the name of Huntingdon and Peterborough was, by leave, withdrawn.

In his opening address Dr. Cameron justified the logic and the propriety of issuing Document SC.12 and reminded the Conference that he and many other members of the G.M.S.C. had, on more than one occasion, resisted proposals for a "go it alone" General Medical Services Committee. "The position now was exactly the reverse, the proposal for severance came not from the Conference but from elsewhere, and it was based, in his view, on unsound reasoning." He spent a considerable time explaining the significance of the correspondence between Dr. Derek Stevenson and Sir Philip Rogers on the representation of the profession, and pointed out that nowhere in Sir Philip's reply had the B.M.A. as such been mentioned at all; only the General Medical Services Committee and the Central Committee for Hospital Medical Services.

After Dr. Cameron had formally moved the G.M.S.C.'s first recommendation, Dr. Metcalfe proposed as an amendment "that this Conference agrees with the decision of the Representative Body accepting the Chambers Report in principle, and insists that all possible steps should be taken by the General Medical Services Committee to cooperate with the British Medical Association in implementing the report". He received support from only one speaker, Dr. Lutton, who attended the Conference as one of the representatives of the Scottish G.M.S.C.\* The amendment was lost. Recommendation 1 was then amended to read:-

"That it be reaffirmed that the system of representation of National Health Service general practitioners should continue in principle to consist of an L.M.C./Conference/G.M.S.C. structure and this does not preclude alteration of the present structure."

When the motion as amended was put to the Conference as the substantive motion twenty representatives demanded a recorded vote in accordance with the standing orders, and it was carried by 224 votes to 15.

The second recommendation too was amended to read:-

"That this Conference requests the General Medical Services Committee to repeat the invitation of 60 years ago to the British Medical Association to provide for the structure to remain within its constitution in terms acceptable to the Conference."

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\* The Scottish G.M.S.C. itself was of a contrary view.

It was opposed by Dr. J.M.K. Deas, one of the M.P.U.'s delegates on the G.M.S.C., who insisted that any compromise solution would lead to future conflict. The G.M.S.C.'s second recommendation, as amended, was carried by 209 votes to 3 with one abstention.

The Conference recognised that the best interests of all parties would be served by maintaining the relationship between the L.M.C./Conference/G.M.S.C. structure in principle and the B.M.A., and expressed the view that no effort should be spared to this end. Local Medical Committees were asked to discover, influence and use the opinions of general practitioners in their area to exert constitutional pressure on their B.M.A. divisions to secure the acceptance of the invitation contained in Recommendation 2.

Dr. R.G. Troup on behalf of the North East London Medical Committee, proposed "that in the event of the British Medical Association providing the structure for the General Medical Services Committee to remain within its constitution the General Medical Services Committee should have autonomous powers comparable with those conferred upon it at Annual Representative Meetings in recent years". Dr. J.H. Marks, seconded by Dr. W.G.A. Riddle, moved by way of an amendment "that the General Medical Services Committee shall have delegated responsibility comparable with that conferred upon it by past Annual Representative Meetings and the Second Schedule to the Bye-laws of the British Medical Association". Dr. Marks said that the word "autonomous" had been used to discredit general practitioners and identify them with those who wished to split the B.M.A. and the profession on partisan lines.



The emotive words "autonomous powers" must be replaced by "delegated responsibility" so that the G.M.S.C. could deal with those issues which were peculiar to the discipline of general practice. Dr. Arnold Elliott, the second delegate from the M.P.U., and a senior member of the North East London Local Medical Committee, opposed the amendment without success.

Dr. Cameron and the G.M.S.C. resisted many amendments to the third motion which recommended the establishment of an independent organisation should the need arise, and it was carried by 196 votes to 23 against with seven abstentions. Dr. Cameron said that with such clear mandates there was no longer any need for an urgent referendum, and the Conference reworded the original recommendation to give him what he wanted - authorisation for the G.M.S.C. to initiate a referendum if it considered it necessary in the light of changing circumstances<sup>1000</sup>.

#### Immediate reactions to the Special Conference

This being the first Conference open to the press, it was fully reported, and commented upon in the para-medical journals under such headings as "G.P.'s threat to quit B.M.A."<sup>1001</sup>, "L.M.C.'s tell B.M.A."<sup>1002</sup>, "Chambers in Principle but not in Practice"<sup>1003</sup>, "G.M.S.C. threat to 'go it alone'"<sup>1004</sup>, "G.M.S.C. wins a powerful ally in Chambers battle"<sup>1005</sup>, "G.M.S.C. breakaway threat"<sup>1006</sup>.

The M.P.U. reiterated its [incorrect] opinion that the G.M.S.C. was not a committee of the Association and warned that any attempt to transfer the G.M.S. trusts to the B.M.A. would constitute a

breach of the trust deed and would be contested, in the Chancery Courts if need be. Some observers recognised that there had been a "grass roots" revolt over Chambers, and that there was at least a possibility that representatives of divisions would be sent to the Annual Representative Meeting at Folkestone with instructions to reject "Chambers in principle"<sup>1007</sup> and Sir Paul's proposals for the Association's negotiating machinery<sup>1003</sup>.

Laurence Dobson interviewed certain of the main protagonists on each side of the debate<sup>1008</sup>. "We believe that inevitably a compromise must be worked out", said Dr. F.D. Proudfoot of Dundee, and Dr. Crowe of the Young Practitioners Sub-committee expressed the hope that the G.M.S.C. would be bold enough to give its negotiators freedom to reach a compromise. Dr. Clifford Lutton insisted that he was not disheartened by the Conference, which had done a lot of good, in that differences of opinion had been heard and many doctors who had not taken any interest were becoming involved. He expressed his belief that in the end it would be the wishes of the rank and file which would have to be satisfied. "If they want a Chambers type of structure and have an understanding of the situation I have no alternative but to support such a structure. My faith is in integration within the B.M.A. My fear is in disintegration outside the B.M.A." Dr. John Marks of the G.M.S.C. said, "We are still in the B.M.A. and given a modicum of statesmanship we will remain in the B.M.A.", a theme that he developed when repudiating the M.P.U.'s claim that the G.M.S.C. was not a committee of the Association<sup>1009</sup>.

An attack upon the Secretary

The G.M.S.C. met the day following the Conference and endorsed the resolutions passed by it. During the debate the Chairman of the Council and the Secretary left the Council Chamber, unaware that they were about to be attacked by Dr. Caldwell. He suggested that the Chairman of the Council and the Chairman of the Organisation Committee should resign, and that the resignation "of certain of the ageing officials who, bereft of new ideas or energy to implement them, seem to be content to coast along from one improvisation to another, from one compromise to another, with a view, I suppose, to retirement, a pension, and possibly some sinecure of a job, should also be considered".

Dr. Gyles Riddle suggested it was not proper to criticise officials of the Association who were not in a position to defend themselves and after the Chairman had suggested that he might have been carried away by emotion Dr. Caldwell withdrew the reference to the officials in his speech. Dr. Noble said that the one message that had come from the Conference the previous day was that virtually everybody present believed that the profession's affairs should be conducted under one roof, namely that of the B.M.A.

After lunch the standing orders were suspended in order that Dr. Stevenson could address the meeting. He reminded the Committee that he had been its secretary for twelve years and denied the accusation of incompetence; the only evidence put forward for this had been his increasing years. He had insisted

that the staff should keep out of the Chambers dispute as far as possible. He defended the agenda committee of the Representative Body and the Council, and gave a full account of the situation as at the date of the meeting. It was agreed that the report of the Conference and the Committee meeting should be submitted to the Council and to the Working Party on the constitution<sup>1010</sup>.

#### Two Reports of the G.M.S.C.

The annual report of the General Medical Services Committee is normally sent to every National Health Service general practitioner without comment or covering letter. The report for 1973 included a summary of the events leading up to the Special Conference of February and a complete list of the Conference resolutions<sup>1011</sup>. A letter from Dr. Cameron was inserted into it. He urged the recipient to study the report carefully and make his views known to his Local Medical Committee or to his member of the G.M.S.C. He drew the reader's attention to the fact that the Annual Report of Council would be published in the Supplement to the British Medical Journal and urged every member of the Association to study it.

"Should you be one of the three out of four family doctors who belong to the B.M.A., you will have the opportunity at some time during the first half of April to attend a Division or Branch meeting to consider this B.M.A. Annual Report.

Among the matters to be considered will be the Constitution and Organization of the B.M.A.; a matter of the utmost importance to all of us. May I make a plea therefore to all B.M.A. Members to

attend their local B.M.A. Meetings? Before doing so I would suggest that they study paragraphs 24 to 29 of the Annual Report of the G.M.S. Committee and the relevant section of the Annual Report of the B.M.A. Council. In particular, one of the appendices to the B.M.A. report, consists of the advice of the G.M.S. Committee following the Special Conference held in February.

I do not apologise for troubling you with this letter and this request. The way in which your interests are to be represented in the future is a matter which is of great concern - and it is in the next fortnight that, up and down the country, this is going to be vitally affected by decisions taken at local B.M.A. meetings." 1012

The G.M.S.C.'s report to the Council on the constitution of the Association included the decisions of the Conference and the original invitation which had been issued to the Association in two resolutions passed by the Conference of Representatives of Local Medical and Panel Committees on March 13 1914:-

"That it is imperative that there be a permanent organisation to co-ordinate the work of local medical and panel committees, and to safeguard and promote the interests of those represented by them" and "that this new organisation should be associated with the British Medical Association."

The Committee explained that there was no desire amongst general practitioners to cut themselves off from their colleagues or from the B.M.A. The report ended as follows:-

"To sum up therefore, the General Medical Services Committee, after consultation with all local medical committees has obtained from their representatives in Conference clear cut decisions determined by majorities of a size which cannot be ignored - nor dismissed as unrepresentative. The Committee has absolutely no alternative therefore but to advise the Council, with all the seriousness and authority which it can command, that the implementation of those principles of the Chambers Report which would abolish the long-established means by which NHS practitioners' interests are represented, will do irreparable harm to both the Association and to the interests of all general practitioners. As these doctors form a group containing one third of the UK Membership this course can fairly be described as disastrous. Accordingly, the G.M.S.C. now invites the Council to take steps to maintain the G.M.S.C./Conference/L.M.C. structure.

Conclusion A: The implementation of those proposals of the Chambers Report which would destroy the present organisation for representing the medical profession in the National Health Service will damage both the interests of the Association and of the profession.

Conclusion B: The General Medical Services Committee on behalf of the Conference of Representatives of Local Medical Committees formally requests the Association to maintain the L.M.C./Conference/G.M.S.C. structure within its constitution.

Conclusion C: Subject to the acceptance of Conclusions A and B discussions should take place on the precise method of implementing Conclusion B.

Recommendation (1) That the above report and its conclusions be supported by the Council.

(2) That the report, its conclusions and appendices be reported to the Representative Body." <sup>1013</sup>

The report was sent to Mr. Walpole Lewin on March 6 with a covering letter from Dr. Cameron urging the Council to show the Representative Body the dangers of a split, not only to the Association, but to the profession as a whole <sup>1014</sup>.

#### Two Reports of the Working Party

The Council met on March 14th and 15th to approve the Annual Report and to consider the two reports from the special Working Party on the constitution. The first document (Document C.42) <sup>1015</sup> provisionally entitled Third Report of the Council to the Representative Body on Sir Paul Chambers's Report, was a draft constitution prepared in accordance with the Representative Body's decision. Although the Working Party had worked extremely hard it had found itself in some difficulty in deciding how much licence it had to depart from "Chambers in principle" because in some instances a structure which embodied all the Chambers principles proved to be so complicated as to be almost unworkable. In a few instances the Working Party drew attention to the difficulties encountered and submitted alternative proposals <sup>1016</sup>.

The report included sixteen specific propositions which would have to be adopted for implementation of the Chambers Report in principle. Propositions A, B and C concerned the area and regional councils;



D and E the Representative Body; F to K the central committees; and M the central executive. Propositions N and O dealt with elections; proposition L the abolition of the Junior Members Forum and Hospital Junior Staffs Group Council; and proposition P defined the position of "junior doctors".

Proposition F was: "That Standing Committees be established with the titles and composition set out in the schedule in Part I of Appendix B to this report." The General Medical Services Committee would have 24 members of whom 12 would be junior doctors. Twelve (6 senior and 6 junior) would be elected by the general practitioner members appointed to the Representative Body by area councils from amongst their own number and 12 (6 senior and 6 junior) would be elected by the general practitioner members appointed to the Representative Body by constituencies from amongst their own number.

The Council spent four hours debating whether the Document really did reflect the genuine Chambers proposals. Proposition M came in for a great deal of criticism, and was drastically modified by the Council.

The Working Party's second report (Document C.43)<sup>1017</sup> took account of the views of the General Medical Services Committee, the Central Committee for Hospital Medical Services and the Hospital Junior Staffs Group Council. The Working Party satisfied itself that fresh information had come to light and that a new situation existed, which needed to be closely examined. "For the

Association the risk of the division within the profession is all too clear. Inevitably if the issues are not resolved there could be a serious risk of weakening the Association's present position." The Working Party doubted whether the concept of autonomy was really such a divisive issue as was first thought, as Chambers would give the Standing Committees at least as much, if not more, autonomy than they already enjoyed. The crucial issue was the method of appointment and composition of the Standing Committees, and the extent to which the Local Medical Committees and the equivalent hospital committees could participate in the formulation of policy and negotiation. The Working Party concluded that there was a strong fund of goodwill and that it should not be impossible to reconcile differences given the necessary time for consultation. With this in mind, the Working Party advised the Council to recommend to the Representative Body:- "That in order

- (i) to overcome the dangers inherent in the present situation,
- (ii) to preserve the unity of the profession, and
- (iii) to ascertain whether there is a possibility of providing a structure within the Association which meets the viewpoint of the C.C.H.M.S. and the G.M.S.C. on terms acceptable to the Representative Body, no decision be taken on proposals F, G and L at this stage, and Council be authorised to initiate the necessary consultations and to present a further report on these proposals to a special meeting of the R.B. as soon as possible."

During the debate on Document C.43 Dr. Cameron again emphasized the seriousness of the situation, but accepted that "autonomy" was

really "delegated authority". He was supported in this view by Dr. Astley. Dr. A.C.D. Brown, deputy chairman of the Hospital Junior Staffs Group Council, said that when the Group Council had first considered the matter it had "fallen in love with the idea of Chambers" but realised later that it did not seem to be a practical reality<sup>1018</sup>. The Council added Recommendation M to the Working Party's list of propositions which should not be implemented<sup>1019</sup>.

A proposal by Drs. Marks and Tomlins to delete the first and second recommendations of the G.M.S.C.'s report, and to submit the whole of the Committee's report to the Representative Body so that it could consider the formal request to the Association to maintain the L.M.C./Conference/G.M.S.C. structure within its constitution, was accepted, on the suggestion of the Secretary of the Association, without a vote.

#### More activity in the periphery

Passions became aroused on a subject which had previously been considered boring and local leaders tried to influence doctors for and against the Report. Drs. Lutton and Marks took part in well attended debates<sup>1020</sup> in Hertfordshire, Torquay and Kingston-on-Thames, at which the Chambers proposals were generally defeated<sup>1021</sup> by majorities of up to ten to one<sup>1022</sup>.

In reply to a question at the Special Conference of February 4th, Dr. Stevenson revealed that two requests had been received from divisions for a Special Representative Meeting. In March the

Chairman of the Council reported that "several such requests had been received" and it had been agreed that it be left to the Chief Officers to requisition a Special Representative Meeting either at, or before, the Annual Representative Meeting in June<sup>1023</sup>. By the end of March nineteen requisitions had been received, one less than the number required to force the Chairman of the Representative Body to call a Special Representative Meeting as required by Bye-law 51 (1) of the Association. Dr. Noble wrote to all divisions concerned explaining the difficulties and at least four of them intimated that they were prepared to withdraw their support for the requisition<sup>1024</sup>. It is significant that, by that time, there was some evidence that the Representative Body's decisions of November were likely to be modified.

#### The Agenda of the Folkestone Meeting

The report of the Council appeared in the Journal of March 31 as arranged<sup>1025</sup>. Due to the shortness of time consequent on the early date of the Representative Meeting, divisions had to consider the report and submit motions and amendments within two weeks. In an interview with Laurence Dobson, Dr. Marks urged general practitioner members of the Association to attend their divisional meetings and to try to persuade them to pass a resolution "insisting that no reorganisation of the Association can be effective if it does not take into consideration the L.M.C./Conference/G.M.S.C. axis and the parallel machinery of regional hospital committees/Conference/C.C.H.M.S."<sup>1026</sup> Article 42 (2) and Bye-law 53 of the Association<sup>878</sup> provide that four weeks

notice shall be given in the British Medical Journal of any motion which, if adopted, will materially affect the policy or constitution of the Association. One hundred and twenty such motions were received;<sup>1027</sup> they included twelve which would rescind (or not implement) the Special Representative Meeting's decision and fifty-one on the proposed committee structure.

In accordance with Standing Order 10 (ii)<sup>1028</sup> the agenda committee\* drafted the following motion: "That this Meeting, in the light of the views held and conclusions reached by various Standing Committees in respect of the acceptance of Chambers in principle by the S.R.M. last November, is of the opinion that a new situation now exists which must be examined very closely in view of the risk of fragmentation of the profession and because the whole package of 'Chambers in principle' may no longer be acceptable, the individual recommendations of the Council on the propositions of the Working Party must be discussed in detail." It became item 54 on the printed agenda and was marked as a priority motion by the agenda committee in accordance with Standing Order 15a; as

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\* The agenda committee has six voting members. For the year 1972/3 they were Drs. Alexander, Riddle, Outwin and Marks, all members of the G.M.S.C., and Dr. Macara and Dr. Cove-Smith who had voted in favour of "Chambers in principle" at the S.R.M. The Standing Orders provided for up to four deputies but there were only two; Dr. Loden, also a member of the G.M.S.C. and Dr. F.O. Wells of Ipswich, a staunch supporter of Sir Paul Chambers and his proposals.

it dealt merely with procedure it required only a simple majority to be effective.

The first motion on the Central Committee structure was item No.121: "That in order (i) to overcome the dangers inherent in the present situation; (ii) to preserve the unity of the profession; and (iii) to ascertain whether there is a possibility of providing a structure within the Association which meets the viewpoint of the C.C.H.M.S. and the G.M.S. Committee on terms acceptable to the Representative Body, no decision be taken on Proposition F at this stage, and that Council be authorised to undertake the necessary consultations with all the committees concerned and to present a further report to the Representative Body as soon as possible."

Motion 124: "That no reorganization of the B.M.A. can be effective which does not take into consideration the L.M.C./Conference/G.M.S.C. structure and the parallel machinery of regional committees for hospital medical services/Hospital Medical Staffs Conference/C.C.H.M.S., and which does not confer delegated authority upon the G.M.S.C., the C.C.H.M.S. and any other committees of similar stature,"\* was also drafted in accordance with Standing Order 10 (ii) to cover a "bracket" containing twenty-six motions and amendments. It was not marked as a priority motion by the agenda committee but, as a result of a ballot by the representatives in accordance with

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\* The Representative Body accepted an amendment to add "for example the Hospital Junior Staffs Group Council" to the motion.

Standing Order 15b, it became a priority motion. Standing Order 15a then applied, and motion 124 was removed from the group.

The divisions included in the group met and produced a "common form motion" identical in wording to motion 124, to be moved by Dr. J.H. Marks in his capacity as representative of the Barnet division.

The agenda committee recommended that the debate on the constitution should start at 3 p.m. on Tuesday, June 5, and continue throughout Wednesday if necessary, and that the business be taken in the order printed on the agenda<sup>1029</sup>.

#### A reversal of policy<sup>1030</sup>

The agenda committee's recommendations were accepted at the beginning of the Annual Representative Meeting. At the appropriate time the Chairman of the Representative Body, who is also the chairman of the agenda committee, formally moved Motion 54. Dr. Roberts of Hendon asked, as a point of order, whether the agenda committee was acting within its powers in producing the motion. He argued that the Committee's actions had placed several competent motions in jeopardy, but the Chairman pointed out that the situation had been explained the day before and the meeting had agreed to the proposed course of action. The first was made by Dr. Ribet of Folkestone, the host division, whose motion, agenda item 55, closely resembled the wording of the composite



motion. There was one speaker in opposition, Dr. Leaming; there was no reply to the debate and the motion was carried by a large majority.

Motion 121 by the Chairman of Council was opposed by Dr. Kearns of West London. But it was supported by Dr. F.O. Wells of East Suffolk whose division strongly advocated the adoption of the Chambers Report in principle. He wanted negotiations, not a fight. The motion was carried by an overwhelming majority.

When item 124 on the agenda was reached the meeting agreed that, as it was likely to be controversial, it should be moved by a member of the agenda committee, Dr. J.H. Marks, rather than by the Chairman. He advanced the well known arguments in favour of the L.M.C./Conference/G.M.S.C. structure and urged the Association to "nurture" the developing National Hospital Medical Staffs Conference. He reminded the representatives that the Junior Hospital Doctors Association was established by dissident members of the Association, and told the Representative Body that the Conference of Local Medical Committees had "killed the myth of autonomy" and had accepted "delegated responsibility"<sup>1031</sup>.

Mr. W.I. Jones of Swansea opposed the motion because he objected to the structure of the C.C.H.M.S. and Dr. Lutton asked what "delegated authority" meant. Dr. Stevenson explained that the Board of Trade would not agree to any constitution which was ultra vires and that in law the Council and the Representative Body were paramount. Dr. Marks intervened and explained what he meant by "delegated responsibility". He quoted the second schedule of the

Bye-laws which provided for the G.M.S.C. "to deal with all matters affecting practitioners providing general medical services under the National Health Service Acts" and for the Central Committee for Hospital Medical Services "to consider and act in matters affecting those engaged in consultant and hospital practice".

The motion was supported by Drs. Astley, Cameron and others, but Dr. Appleyard maintained his opposition to the Central Committee for Hospital Medical Services and autonomy. Dr. Lutton was prepared to accept the first part of the proposal, but not the second.

Dr. Crawford asked three questions before Dr. Marks replied to the debate. This gave Dr. Marks the opportunity to state that if the motion was passed "Chambers in principle would have been effectively disbanded".

A request for a "roll call" signed by fifty representatives was handed to the Chairman; the roll was called and the motion was passed by 246 votes to 86\* which was more than the two thirds

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\* The number of votes varied in different accounts of the meeting. The leading article in the British Medical Journal quoted 246 to 86<sup>1032</sup> as did "Pulse"<sup>1031</sup>; "On Call"<sup>1033</sup>, "Doctor"<sup>1034</sup> and "General Practitioner"<sup>1035</sup> preferred 243 votes to 84, whilst "Medical News"<sup>1036</sup> gave the figures as 246 to 80. At the time of writing the official minutes had not been issued.

majority necessary to change the policy of the Association.

### Autonomy for the Juniors

On the last day of the Annual Representative Meeting

Mr. Walpole Lewin moved the Annual autonomy resolution i.e.:-

"The autonomous powers of the General Medical Services Committee and the Central Committee for Hospital Medical Services be renewed in respect of the year 1973/4 on the understanding that no action be taken by either of these committees which may prejudice the interests of another part of the profession without full prior consultation with the interests concerned and that their autonomous powers be used so as to expedite the work of the Association."

An amendment by Dr. Roberts of Hendon to substitute "agreement" for "prior consultation" was defeated, as was another drafting motion by Dr. Hendry of Rugby. Mr. F.J. Bramble, representing the Leeds Regional Hospital Junior Staffs Group Council, moved an amendment to add the words "and that pending the implementation of a new constitution of the British Medical Association, the same autonomous powers be given to the Hospital Junior Staffs Group Council for the year 1973/4". This was supported in principle by Dr. C.E. Astley, Chairman of the Central Committee for Hospital Medical Services and by Drs. Lawrence, Cameron and Lutton.

Dr. Crawford asked yet another question; whether the amendment, representing a change of policy, was constitutional. Dr. Stevenson and Mr. Walpole Lewin agreed that, in view of the passing of motion 124, the motion was acceptable. The Chairman then ruled

that the amendment was a permissive proposition, to be regarded as an addendum to bring the motion into line with early decisions of the meeting.

Dr. Henneman of Bournemouth opposed the motion granting annual autonomy, arguing that this meant self-government. He criticised the G.M.S.C. for issuing Document SC.12 which he claimed showed a lack of consultation and of concern for the interests of other parts of the profession. He had a very hostile reception from the representatives who objected to his trying to re-debate matters which had been decided by such overwhelming majorities.

THE G.M.S.C. INSIGNIA

Desmond Morris,<sup>1037</sup> writing on the subject of friction between various sub-groups within a single culture, postulated that when hostilities were about to break out habits of dress became flamboyant, and that the appearance of "armbands, badges and even crests and emblems become a typical feature".

During the early part of 1970, whilst the G.M.S.C. was still meeting in Committee Room A, Dr. John Ball drew a cartoon which ridiculed the G.M.S.C. It was circulated amongst the members and the idea developed of a G.M.S.C. emblem to be worn on a tie. In October the following items appeared on the agenda of the G.M.S.C.:-

"Consider: Following item which was included on the Agenda for the last meeting of the Committee and which has been referred back to the Committee by the Chairman:-

- (1) Following letter (8.6.70) from J.G. Ball to the Chairman of the Committee:-

'There has, for several months, been informal discussion among members on the subject of a G.M.S.C. tie, to be worn in recognition of present and past service on the Committee. Dr. Gullick has done the necessary research to provide the background information, and the following steps or decisions would seem appropriate.

- 1) For the G.M.S.C. to decide in favour of the basic issue.
- 2) To decide whether to have an official and approved coat of arms drawn up by the College of Arms - with the cost inevitably involved, or -
- 3) To agree an informal design of tie which could be adopted.

I realise that this matter stands nowhere in the current list of priorities, but would seek its inclusion in some later Agenda at an appropriate time.'

(2) Following note by the Secretary of the Committee:-

'I think Dr. Ball and I both started thinking of the possibility of a Committee tie at about the same time. I was aware of course of the Middlesex L.M.C. tie, and for some years the B.M.A. tie has raised money for charity, in addition to pandering to the weaknesses of those of us who value such tribal emblems. Certainly my idea was twofold - a distinguishing mark for members of what is, off duty, a very friendly club, and a source of further help for the Dain Fund.

Dr. Ball refers to my contacts with the College of Arms and its heraldic Officers. I never had in mind that the Committee, like the Association, should obtain a Grant of Arms, such as that which adorns the Hastings Room. Such an exercise would not be inexpensive - and I am not sure whether any body, other than an individual or a corporate body, can in fact be granted Arms. I went to the College only to see the arms of Sir Henry Brackenbury.

Sir Henry, whilst not actually the first chairman of the Insurance Acts Committee (when it was set up the then Chairman of Council presided over the first meetings), was undoubtedly the architect of the "G.M.S./Conference organisation", and the deviser of the duality and of the

autonomy within the B.M.A. It seemed to me therefore that if Sir Henry had borne Arms, some feature of those Arms could very properly form the emblem of a G.M.S.C. tie. Such a choice would be a compliment to the memory of the Committee's de facto founder, and would be less trite than any emblem incorporating initials or a serpent or some article of equipment peculiar to the N.H.S. general practitioner.

In fact Sir Henry bore Arms even before being Knighted (when later Chairman of Council), for his father - a Methodist parson in Wiltshire - established his claim to Arms early in this century. (The Family is an old one: Sir Robert Brackenbury was the Lieutenant of the Tower of London in King Richard III). Without attempting in the heraldic Norman tongue to describe what I was shown at the College, the Arms contain a number of devices any one (or two) of which could be woven into a tie:- the red lion rampant (as in the Scottish Arms), a golden acorn with green oak leaf, a black lion couchant, and two interlinked chevronets (lance corporal's triples).

Should a tie be decided upon, and should it be agreed that the emblem(s) be based on this Coat of Arms, I would suggest a very small 'Tie Working Group' charged with producing a prototype for the Committee's consideration. Its members could be the Chairman and Dr. Ball, with such help as the B.M.A. Bursar and myself can give'." 1038



A tie working group was established. Drs. Ball and Gullick were appointed by the Committee and they coopted Dr. Ben Holden of Macclesfield who had connections with the silk industry in that town. The group submitted two possible designs to the Committee, a "city tie" based on the Arms of Sir Henry Brackenbury and a "club tie" showing a cockerel with two heads on a weather-vane marked 'GMSC'.\*

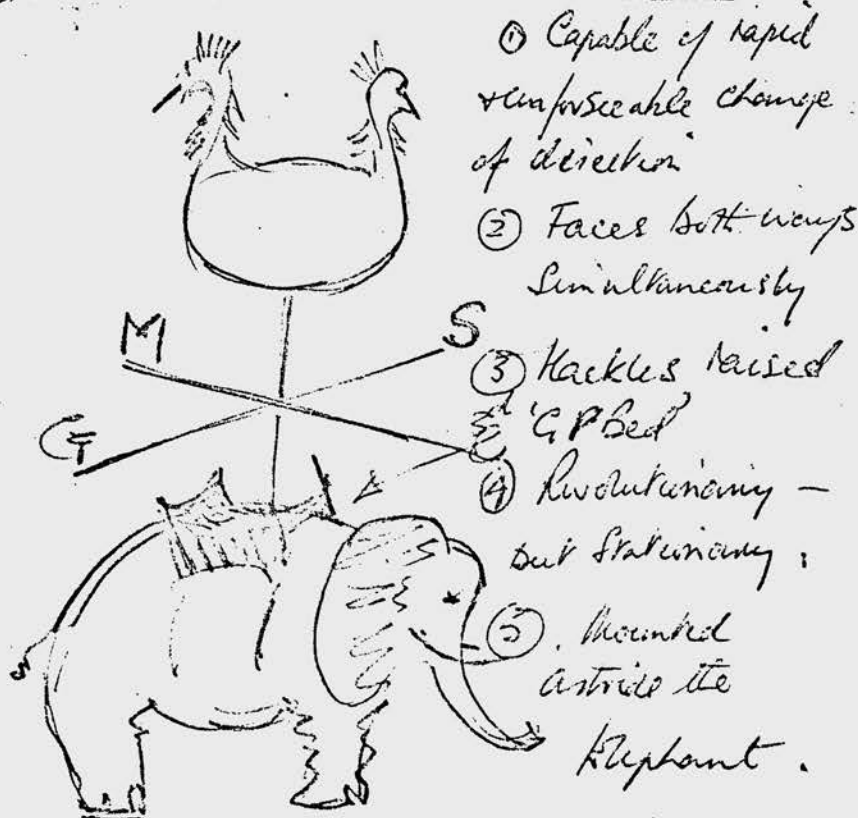
The Committee accepted both designs and agreed to sell the tie to past and present members and others "with close ties with the Committee", any profits to be given to the Dain Fund, a charity whose object is the provision of education for the children of deceased general practitioners.

There was a great demand for the ties which became available during 1972. They were worn by many members at open meetings, meetings of Local Medical Committees, the General Medical Services Committee and the Conference whilst the Chambers crisis was on. They were conspicuous by their absence at Folkestone. The ties had a considerable effect on the morale of the General Medical Services Committee which, at the time, felt itself to be in danger of extermination. At the time of writing a second edition of the tie, with a background of a different colour, is being considered.

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\* The group's report, Document G.M.S. 1212 of 1066/67 (sic) mimicked one of the normal reports of a working party but was written in a flamboyant and humorous style<sup>1039</sup>. (See Appendix 6)

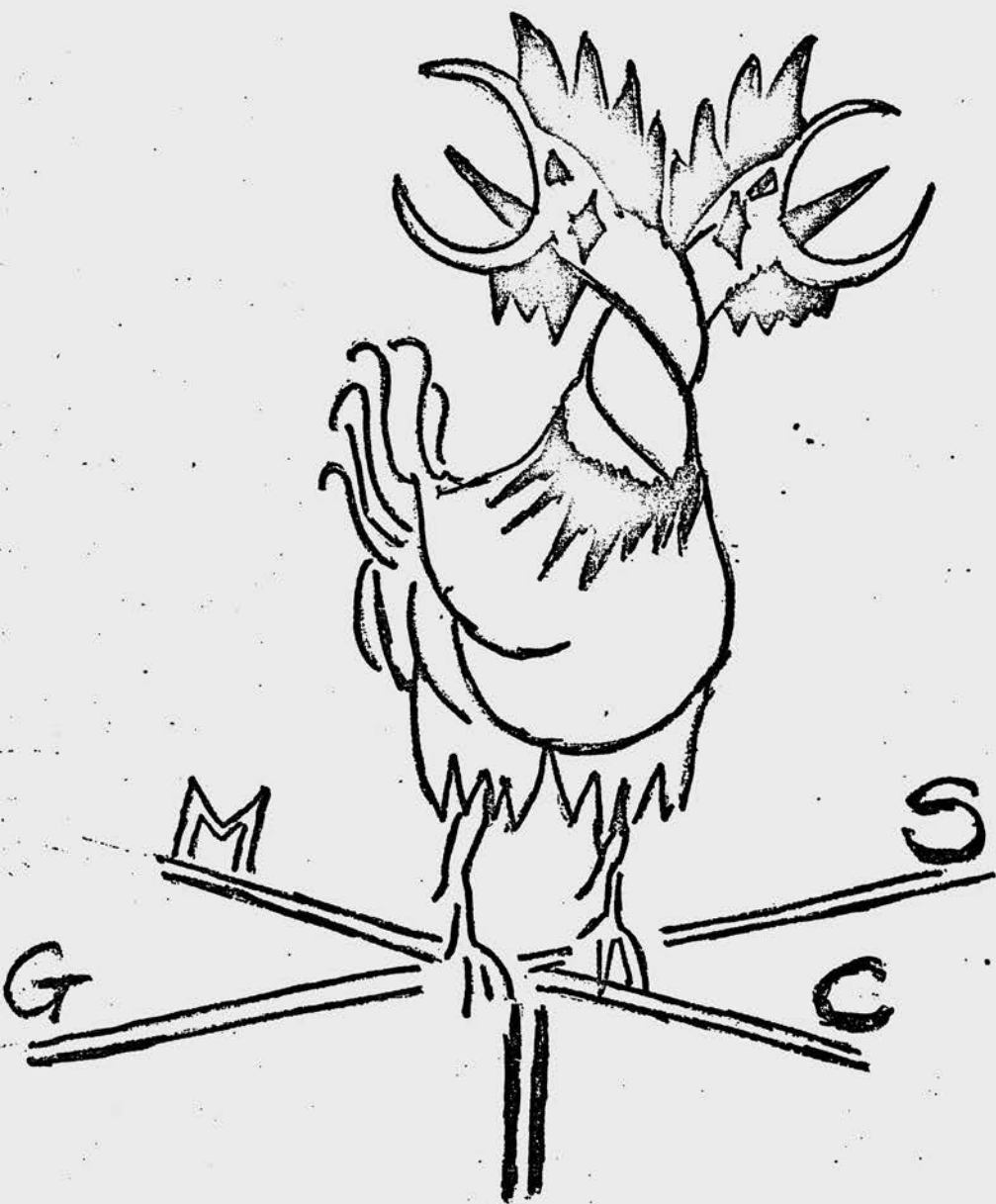
Please Circulate.  
 BRITISH MEDICAL ASSOCIATION  
 and note to Jno BARK Notes



## GMSL EMBLEM

Notes "Virtue is its own reward"

Ties Terrylen 20/- } under negotiation  
 Revised quarterly Scr 30/- } with the Dept-  
 (of the Multiple Store)  
 Thereby certifying no change in circumstances since last submitted. ? level of reimbursement.



*John*

BASE COLOUR GOLD

RED - AREAS + LETTERS G M S C  
MARKED

LETTERS G M S C CAN BE ENLARGED IF NECESS

THE SECRETARIAT OF THE CONFERENCE AND ITS EXECUTIVE

The Medical Secretary of the B.M.A., Dr. Cox, issued the documents which lead to the establishment of provisional local medical committees by the local units of the Association on the instructions of the State Sickness Insurance Committee<sup>35</sup>. Although he was not directly involved in convening the Conference at Brighton<sup>65</sup>, he and his staff organised and assisted the first Conference of Local Medical and Panel Committees in 1914<sup>115</sup>. The Insurance Acts Committee offered the proposed Federation of Panel Committees premises, clerical help and other facilities. Thus the secretariat of the Association, through the I.A.C. and its successor, became the secretariat of the Conference.

The post of Secretary of the I.A.C. was first held by Dr. Cox, but later Dr. Anderson, the Deputy Medical Secretary, took over. When he was promoted he found that his new duties did not permit him to devote the amount of time necessary for the efficient supervision of the Committee's work;<sup>377</sup> his place was taken by his deputy, Dr. Forbes. This pattern has persisted; the present Secretary of the B.M.A., Dr. Stevenson, was Secretary of the G.M.S.C. for twelve years, and was succeeded by Dr. Walter Hedgcock, the Principal Deputy Secretary. In 1968 Dr. David Gullick, Under-Secretary of the B.M.A., took over the job and in 1973 he changed places with the other Under-Secretary, Dr. John Harvard, who had been serving the Central Committee for Hospital Medical Staffs.

At the Conference of 1922 Dr. H.J. Cardale, on behalf of the London Panel Committee, proposed that a full-time secretariat should be appointed under the control of the I.A.C. He considered that it was unreasonable to expect part-time officers to afford the constant vigilance which was necessary to protect the interests of panel practitioners, and he asked that the matter be referred to the I.A.C. for consideration. Dr. Brackenbury pointed out that panel practitioners did not want their affairs segregated from the rest of the profession, and the motion was lost<sup>161</sup>. In 1942 the Annual Conference requested that the I.A.C. should consider a suggestion that a special section of the central secretariat and staff should be created. The Committee considered that segregation would be less effective than a regional secretariat and advised the Conference accordingly<sup>1040</sup>.

The Secretary of the G.M.S.C. consults with officials of the Department of Health and other organisations on routine matters. He is accountable to the Secretary of the B.M.A., who in turn is accountable to the Council. Along with other officials of the secretariat he has a "parish priest" role for a number of the Divisions of the Association. His salary, and that of some of his staff, is paid by the B.M.A., but a part of the staff wages bill is met from the general practitioners' defence trusts. During the Chambers crisis there was speculation that if the G.M.S.C. left the B.M.A. its Secretary and staff would find their loyalty under test; they would either have to desert the B.M.A. or leave the break-away G.M.S.C. to fend for itself.<sup>986</sup> At no time was there any suggestion that this division of loyalty existed in

reality, and the decisions taken at Folkestone allowed the staff to continue to serve both the membership of the Association and those doctors who secure representation, through its committees, without joining.

THE PRESS AND THE CONFERENCE

The first Conference of Representatives of Local Medical Committees passed almost unnoticed. A fairly full account of its proceedings was given in the British Medical Journal<sup>71</sup> but the Lancet, although invited to attend,<sup>67</sup> ignored it as did the national daily papers, with the exception of the Morning Post<sup>1041</sup>. The local press usually gives a lot of space to the Annual Representative Meeting of the British Medical Association, and the south coast newspapers were no exception. The Brighton and Hove Times, in a full page account of the Association's activities of July 24 1913, included the following:-

"In the afternoon the representatives of Local Medical Committees met in conference, and this was followed by the Mayor and Mayoress of Hove's garden party....."<sup>1042</sup> The other papers did not report the Conference at all.

The activities of doctors, and their pay, have a fascination for the lay public, and have therefore been reported and commented on extensively. At times the facts have been distorted and the comments biased, either to fit in with the political affiliations of the newspaper and its proprietor, or to fulfil the requirements of sensationalistic journalism. Although the general press was excluded from the Conference until 1972,<sup>14</sup> the official reporter of the British Medical Journal was always present, and the Conference has issued statements on appropriate occasions through the B.M.A. and its press office. In addition members of both the



Conference and its executive have been guilty of leaking information to the press for a variety of motives<sup>917</sup>.

In 1913 the Star<sup>51</sup> and other Liberal papers, such as the Wisbech Chronicle,<sup>1043</sup> attacked the attitude of the doctors and their Local Medical Committees towards the introduction of National Health Insurance. On the other hand the Daily Telegraph, which favoured the opposition, gave considerable support and publicity to the London Medical Committee<sup>55</sup>.

In the early part of 1923 the Rothermere Press conducted a virulent campaign against the panel system and the doctors working in it. Later in the year, when the doctors were in dispute with the Government and the Approved Societies, their case was treated sympathetically by The Times<sup>222</sup> but the Manchester Guardian<sup>1044</sup> published a leading article expressing doubts as to the real attitude of the profession towards the panel system, and the left-wing Daily Herald claimed that its post-bag revealed a divergence of opinion amongst trade unionists<sup>1045</sup>. Some were glad that the doctors were prepared to adopt the strike weapon, whilst others thought that the practitioners were already overpaid. Although the Conference was mentioned occasionally, most of the papers concentrated on the B.M.A. and the I.A.C.

Forty years later, during the crisis which followed the Review Body's first report, Pulse, a newspaper specifically designed for general practitioners, paid little attention to the Conference and devoted its space to reports of the activities of the B.M.A. and

the General Practitioners Association. Similarly, in 1970, when the doctors' pay dispute acquired such political importance that it was mentioned in newspapers overseas,<sup>1046, 1047</sup> "the B.M.A." once more received all the credit for the doctors' successful industrial action.

The significance of these events and the impending examination of the B.M.A.'s constitution was not lost on the newer members of the G.M.S.C. who helped to establish the Working Party on Press and Publicity. Its recommendation that the press be admitted to the Conference was opposed by the more conservative senior members of the Committee; during the debate fears were expressed that the presence of the press would prevent those attending the Conference from speaking as plainly as they would otherwise have done.

Dr. Gethen, unaware that he was to become the chairman of the first Conference to be open to the press, said that it was complete nonsense to suggest that the electorate would be better informed if the press was admitted<sup>922</sup>. Fortunately the Conference decided, by one vote, to admit the press<sup>910</sup>.

During the Chambers crisis that followed shortly afterwards, the members and supporters of the G.M.S.C. found ways of bringing the advantages of the L.M.C./Conference/G.M.S.C. structure to the notice of the profession and the laity; the Special Conference of February 1973 was well publicised beforehand in The Times<sup>985</sup> and such journals as Pulse<sup>984</sup> and World Medicine<sup>986</sup>. Its decisions were well reported, there was serious comment on them, and the interest aroused was sustained throughout the spring whilst the

Council's report and the Agenda of the Annual Representative Meeting were being discussed in the Divisions of the Association. There is no doubt in the author's mind that this press publicity played a very large part in persuading the members of the B.M.A., and therefore the Representative Body, that it was necessary to reverse the decision to accept "Chambers in principle".

THE IMPORTANCE OF THE CONFERENCE AND THE "AUTONOMY ISSUE"

The relationship between the B.M.A., the Conference of Local Medical Committees and the G.M.S.C. has been misunderstood, even by such experts as Eckstein<sup>1048</sup> who wrote:-

" [the G.M.S.C.] is responsible, in purely constitutional terms to the Conference of Local Medical Committees, but that, as we have seen is not a very important body; at the very least, in the words of its Chairman\* 'the G.M.S.C. has an association with the B.M.A.'".

The importance of the Conference and its Executive

In 1920 the Minister of Health, addressing a deputation from the B.M.A., complained about the number of bodies that claimed to represent the profession. The Association pointed out that in

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\* Eckstein's book was published in 1960, but in a footnote he mentions that the period covered in the study ended in 1955<sup>1049</sup>. The Chairman that he quoted was Dr. Wand who had been replying to a motion, at the Conference of 1949, which sought to establish that the G.M.S.C. was responsible to the Conference alone and not to the Representative Body. He was supported by Dr. Gray, who said "A gentleman never claimed to be one, but simply took it for granted. The Committee, like the Insurance Acts Committee before it, had not claimed to be an 'autonomous body'; it had assumed it, and the arrangements, without too much probing amongst the constitutional definitions, had worked well."<sup>507</sup>

National Health Insurance practice the Conference of Local Medical Committees had been officially recognised as being able to speak on behalf of all 14,000 panel practitioners<sup>1050</sup>. The Commissioners of Insurance attached such importance to the Conference that two of them attended it, accompanied by members of their secretariat, in 1916<sup>134</sup>; the following year they described it as the "mouth-piece" of the Local Medical and Panel Committees<sup>139</sup>.

In 1923 the Conference rejected a ministerial decision on the size of the capitation fee, and under its instructions the I.A.C. organised a successful "industrial action" by persuading 95% of panel doctors to submit their resignations from the scheme. The establishment of the Court of Inquiry was described as a great victory;\* although the Court recommended a reduction in payment it was considerably less than that which the Minister wished to impose, or that which was urged by the officials of the Approved Societies. This result too was considered to be a victory for the I.A.C. and the Association<sup>301</sup>.

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\*The National Insurance Gazette,<sup>1051</sup> under the headline "The Great Victory" said:-

"Dr. Brackenbury, the doctors' leader, tells them they have won a great victory. Mr. Rockliff, as an Approved Society leader, says the same thing. It is perhaps as well, for it will help the general practitioner, on whose behalf the dreadful battle has been fought, to reconcile himself to the 'victory'."

After the establishment of the National Health Service three Ministers of Health attended the Conference and addressed it. Mr. Iain Macleod spoke on the rising costs of drugs in 1953;<sup>1052</sup> Mr. R.H. Turton spoke in 1956 on the high standards of the general practitioners and their accommodation<sup>1053</sup> and Mr. Enoch Powell "exploded the myth that British doctors are emigrating" at the Conference of 1962<sup>624</sup>.

Successive Ministers of Health negotiated with the I.A.C. and the G.M.S.C., and in 1972 the Secretary of State for Health and Social Services, Sir Keith Joseph, became the first member of the Government to attend a meeting of the Committee<sup>847</sup>. Sir George Godber, the Chief Medical Officer of the Health Department, visited the G.M.S.C. in 1969, and took part in a discussion on the place of general practitioners in the hospital service<sup>1054</sup>. Three years later Sir Philip Rogers, the Permanent Secretary, \* accompanied by the Second Chief Medical Officer, Dr. Henry Yellowlees, attended a meeting of the Committee and discussed the proposed management arrangements in the reorganised National Health Service with the members<sup>853</sup>.

During the Review Body crisis of 1970 the Secretary of the B.M.A. impressed on the Prime Minister that the Conference of Representatives of Local Medical Committees was expecting to hear news of a decision on the Review Body's Report<sup>780</sup>. The G.M.S.C. insisted

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\* He was not the first Permanent Secretary to visit the Committee; one had visited the I.A.C. in 1946<sup>460</sup>.

that the duties and powers of the Family Practitioner Committee should be defined by Statute, and not be prescribed by Regulations. The Government moved the necessary amendment at the Report Stage and the following Section was added to the Act:-

Section 7(3) It shall be the duty of each Family Practitioner Committee in accordance with regulations -

- (a) to administer, on behalf of the Area Health Authority... the arrangements.... for the provision of general medical services, general dental services.....; and
- (b) to perform such other functions relating to those services as may be prescribed<sup>858</sup>.

The G.M.S.C. was consulted on all draft circulars and regulations concerned with general practice in the reorganised service, and many of them were altered following representations by the Committee's negotiators.

These events, the Charter negotiations, the Chambers crisis, and many others, suggest that even if Eckstein's opinion was correct in 1960, which the present author would dispute, it is certainly incorrect in 1973, and the Conference is, in fact, an important medico-political body.

#### The Autonomy Issue

The Chambers crisis was the most recent and the most serious manifestation of a problem which dates from 1913, when the first Conference decided that there should be "cooperation" between the Local Medical Committees and B.M.A. divisions and not "fusion".<sup>71</sup>



The membership of the Association had risen to 26,500 by 1912, but it fell between 1913 and 1918, partly due to the war but largely due to a feeling of dissatisfaction over the National Health Insurance Act.<sup>11</sup> Ten years passed before the Chairman of the Organisation Committee could inform the Council that the membership was again 26,000.<sup>1055</sup> Dr. Henry Brackenbury, "a man of great culture and learning - the wisest leader and best speaker the B.M.A. ever had"<sup>1056</sup> persuaded the Conference to accept a B.M.A. committee as its executive and then persuaded the B.M.A. to allow non-members to sit on one of its major committees,<sup>148</sup> but over the years there were many motions on the Conference agenda demanding complete autonomy for the G.M.S.C. and its predecessor. All were resisted by the elected leaders.

There can be no doubt that the G.M.S.C. is a Committee of the B.M.A. The Insurance Act Committee was established by the Representative Body as a Standing Committee in 1913<sup>70</sup>, two days before the first Conference. The change of name to the Insurance Acts Committee" was made by the Association, and the change to "The General Medical Services Committee" was approved by it<sup>488</sup>. Peter Pain, Q.C., in a legal opinion obtained for the G.M.S.C. during its examination of the Industrial Relations Bill and before the Chambers crisis developed, wrote:-

"The Committee is a powerful body but its origins are distinctly humble on paper; it is simply one of the Standing Committees mentioned in the Schedule to the Bye-laws of the B.M.A." <sup>1057</sup>

During the G.M.S.C.'s debate following the Special Representative

Meeting on the Chambers Report this opinion strengthened the hand of those who wished to maintain the relationship between the Conference and the Association, which had been repeatedly attacked, not only from outside the Association but also from within it.

The most serious challenger to the B.M.A. has been the Medical Practitioners' Union, which "has long nurtured mad dreams of supplanting the BMA altogether in its work for GPs"<sup>986</sup>. Many of its leading members have been prominent in B.M.A. and Conference affairs and its two current delegates on the G.M.S.C. are both active members of the Association; one of them, Dr. Arnold Elliott, is a Fellow. The M.P.U., as a branch of the Association of Scientific, Technical and Managerial Staffs, is not registered as a Trade Union under the Industrial Relations Act, whereas the G.M.S.C., through the B.M.A., enjoys the protection of being on the Special Register<sup>894</sup>.

The "London Medical Committee"<sup>48</sup> and the London Panel Committee both had a close relationship with the M.P.U. as a result of cross-membership,\* and the London Panel Committee was instrumental in establishing the Association of Panel Committees in July 1917<sup>142</sup>. This posed a threat to the I.A.C. for only a short time<sup>156</sup>, but even after its failure the London Panel Committee maintained its opposition to the I.A.C., and only agreed to nominate a representative as late as 1921<sup>196</sup>. The M.P.U. asked

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\* See pages 52-54 above.

for direct representation on the I.A.C. in 1922 and discussions took place between the two bodies, but the I.A.C. recommended that the request be rejected<sup>1058</sup>. Proposing an amendment to allow the I.A.C. to coopt members of other medical organisations [i.e. the M.P.U.] on behalf of the London Panel Committee Dr. Gregg explained to the Conference that "he was 'a B.M.A. man' and would be representing his Division [at the Annual Representative Meeting] at Portsmouth". During the same debate Dr. Cardale (who became Chairman of the Conference in 1930) insisted that he represented the London Panel Committee on the I.A.C., and not the M.P.U.<sup>1059</sup> The Union's request was rejected, as was a similar attempt made on its behalf by Dr. Gordon Ward in 1943<sup>427</sup> to have representation on the committee appointed to study the Beveridge proposals.

The M.P.U. supported the establishment of the National Health Service. In its Golden Jubilee issue Medical World claimed that "Nye Bevan, the Minister of Health, never forgot the part Medical World and Medical Practitioners Union played in the birth of the N.H.S. and frequently spoke of it when meeting members" [of the M.P.U.]<sup>1060</sup>. Mr. Bevan exerted pressure on the G.M.S.C. to allow the Union to have seats on it<sup>517</sup> and the Committee accepted the idea, but the decision to permit its implementation had to be made by the Representative Body<sup>521</sup>. The M.P.U. has continued to form its own policies, which are not always in line with those of the G.M.S.C.; for example it is implacably opposed to the Review Body machinery<sup>1061</sup> and believes that the elected negotiators should be replaced by full-time professional trade union officials.

The General Practitioners Association was founded in 1963 because many general practitioners were discontented with the performance of both the B.M.A. and the M.P.U.<sup>1062</sup> The formation of the new organisation was linked in the minds of doctors and others with the magazine "Pulse", which, although founded by a drug company, had been independent since November 1961; the paper categorically denied any interest in organising a general practitioners' association<sup>638a</sup>. Both the B.M.A. and the M.P.U. expressed doubts as to the value of a third body claiming to represent general practitioners,<sup>1063</sup> but the G.P.A. considered itself of sufficient standing to present a petition to Parliament<sup>1064</sup>. In 1964 it conducted a ballot, in which 7229 general practitioners took part, on the advisability of approaching the Review Body on the evidence contained in the G.M.S.C.'s Document S.C.7<sup>1065</sup>.

The Conference elected a prominent member of the G.P.A., Dr. A. Speakman of Liverpool, to the G.M.S.C. in 1967<sup>1066</sup> and he became a direct representative for "Group D" in the next session, but he did not seek re-election<sup>1067</sup>. At the time of writing the G.P.A. has failed to secure separate representation on the G.M.S.C. and its role in medical politics is insignificant.

The relationship between the Conference and its executive has also been resented by some members of the B.M.A., because non-members could influence an Association Committee. Even Dr. E.R. Fothergill of Brighton, who had signed the letter inviting Local Medical Committees to the first Conference<sup>67</sup> insisted, ten years later, that the B.M.A. membership had the right to question the I.A.C.'s

policy after it had been endorsed by the Conference of Local Medical and Panel Committees<sup>245</sup>. On several occasions votes of no confidence in the Committee have been proposed at B.M.A. meetings<sup>753</sup> and one was passed at a conference of Home Divisions of the Association in 1941<sup>1068</sup>. The crisis of 1964/5 demonstrated that although the General Medical Services Committee was not bound by the decisions of the Conference it could not ignore them; furthermore the Conference was prepared to support the Council if it adopted a more realistic line than that of the G.M.S.C.

#### Two Autonomous Bodies

In 1948, when the G.M.S.C. replaced the I.A.C., the Central Consultants and Specialists Committee of the Association became an "autonomous body with full powers to determine policy on consulting and specialist matters, and take action through the administrative machinery of the Association"\* <sup>1069</sup>. To avoid any doubt as to its powers the C.C. & S. Committee asked that the words "the decisions of the Committee within that sphere shall not be subject to approval of the Council or the Representative Body" should be added to its terms of reference.<sup>1070</sup> This request was granted by the Representative Body, which met at Harrogate,

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\* Later in the year the C.C. & S. Committee became a constituent of the Joint Consultants Committee, which was established to conduct negotiations on behalf of all consultants working in the National Health Service<sup>550</sup>.

but the Council were instructed to look very fully into the relationship between the autonomous bodies and the Association<sup>1071</sup>.

The following year the Council gave a lucid account of a very complicated situation<sup>1072</sup>. It explained that the G.M.S.C. and C.C. & S.C. were Standing Committees of the Association to which the Council and the Representative Body had delegated certain powers which gave them a measure of autonomy beyond that enjoyed by other Standing Committees. "The G.M.S.C. is also the executive of a body which has no place in the written constitution of the Association (except to the extent that the membership of the committee includes six members appointed by the conference)". The Council emphasized that the Government recognised Local Medical Committees as the local bodies representative of medical practitioners for the purposes of the National Health Service, and that any body which purported to voice the views of the general practitioners to the Government must be representative of Local Medical Committees. The G.M.S.C. was such a body. The Council's report continued:-

"In practice the General Medical Services Committee and the Conference of Local Medical Committees are just as closely related to the Association as were the old Insurance Acts Committee and the Conference of Local Medical and Panel Committees. The experience of the past thirty-five years shows that during the whole of the time that these bodies have acted autonomously no practical difficulty has arisen between the Insurance Acts Committee and the Council and between the Panel Conference and

the Representative Body. It is true that in theory the General Medical Services Committee (and the old Insurance Acts Committee) could be composed predominantly of non-members of the Association, but this has not happened.... The position today remains as it was in the days of the old Insurance Acts Committee - that the committee dealing with general practice exercises autonomy within its own field, recognizing that when its activities extend outside that field to matters affecting other sections of the profession the convenient and acknowledged forum for the discussion of such matters is the Representative Body. The liaison has the further advantage that, if and when the General Medical Services Committee needs the support of the whole profession on an issue within its own sphere, the channel through which that support may be obtained is the Council and the Representative Body. Conversely, any recommendation of the Council or of the Representative Body is regarded as having the greatest possible force in the deliberations of the General Medical Services Committee and the Conference of Local Medical Committees. None of these considerations need affect the overall supremacy of the Representative Body on issues which are common to the whole profession....."

The Council reached the conclusion that no useful purpose would be served by disturbing the existing arrangements, but the Representative Body accepted an amendment from the Bromley Division that the autonomous powers of the G.M.S.C. and the C.C. & S.C. should be renewed by successive Annual Representative Meetings<sup>1073</sup>. At the next Annual Representative Meeting, when the Chairman of Council moved "that the Autonomous powers of the General Medical Services Committee and the Central Consultants and Specialists



Committee be renewed in respect of the year 1951/2",  
 Dr. A.C.E. Breach of Bromley proposed the addition of the  
 following rider:-

"The Representative Body looks to these Committees to ensure  
 (1) that no action is taken by either which may prejudice the  
 interests of another part of the profession without full prior  
 consultation with the appropriate interests, and (2) that their  
 autonomous powers will be used so as to expedite and not delay  
 the work of the Association."

Both the recommendations and the rider were adopted.

Dr. J.A. Gorsky, on behalf of the Westminster and Holborn  
 Division then proposed:-

"That this meeting considers that, in the light of recent events,  
 the obvious disadvantages which have accrued from the autonomy of  
 certain standing committees of the Association have created  
 situations which are detrimental to the interests of the profession,  
 and calls upon these autonomous bodies to act strictly in  
 accordance with Bye-law 82 of the Articles of Association, 1950 -  
 namely, 'All standing committees shall report to and act under  
 instructions of the Council'."

The motion was opposed by the Chairman of Council and by Dr. Wand,  
 the Chairman of the G.M.S.C., who had just been elected as  
 Chairman of the Representative Body. Dr. Gorsky, Dr. E.C. Warner  
 and others were especially dissatisfied with the complete autonomy  
 which had been granted to the consultants and specialists, and  
 their relationship with the Joint Consultants Committee. But

Dr. T. Rowland Smith, Chairman of the Central Consultants and Specialists Committee defended the J.C.C., and reminded the representatives that he, a B.M.A. man, was its vice-chairman. In spite of this, the motion was carried by 131 votes to 96.\*<sup>1074</sup>

The ill-defined constitutional machinery continued to function tolerably well. For example, in 1957 the Conference suggested that the Association, of which it was not a part, should take legal action against the Government on the Spens issue<sup>588</sup>. In 1960 the G.M.S.C. decided that it was in the profession's interest that the Council should discuss the Royal Commission's Report with the Government, and that it was unnecessary for the Committee to be directly represented in the negotiations<sup>608</sup>. But a few weeks later, when the Council was considering the "package deal" and Drs. Jones and Noble proposed that the B.M.A. should accept the Government's offer and should negotiate with it on the formation of Working Parties, Mr. Heber Langston, Chairman of the C.C. & S.C., (who had spoken in favour of the Westminster motion in 1951) reminded the Council that only the J.C.C. could accept the Report on behalf of hospital staffs. Dr. A.B. Davies said that the G.M.S.C., as a standing autonomous committee, could not

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\* Commenting on the debate, the British Medical Journal said:-

"Logic is clearly on the side of this resolution. Nevertheless, it is a national characteristic not to carry logic too far and to ignore effectual propositions when they appear to go against good sense and harmony of working." <sup>1075</sup>

allow the Council to tell it what to do or how to do it<sup>1076</sup>.

The effectual illogicality

Sir Paul Chambers, asked to look at the B.M.A.'s constitution as an outsider with no prejudices, or knowledge of medico-political realities, produced the logical solution to the autonomy problem - abolition of the autonomous bodies and the establishment of a unified straight-line management responsible only to the Representative Body. A combination of factors lead to the acceptance of "Chambers in principle" by the Representative Body; the excellence of the Report; the almost contemptuous dismissal of the proposals in it by the Special Conference of November 1972<sup>852, 950</sup> which engendered a false sense of security in those members of the Conference and G.M.S.C. who were also members of the Representative Body; Sir Paul's speech at the Special Representative Meeting and the emotional response that it aroused<sup>983, 986</sup>; the well-known unpredictability of the Representative Body<sup>709, 766</sup> and the resentment of some members towards the apparent loss of influence of the local units of the Association.\*

The G.M.S.C. was saved from extinction because it was able to use the medico-political expertise of its members, its constitutional position within the Association, and its financial independence from it. The vast bulk of the Committee's funds are provided, not by the B.M.A., but by the Local Medical Committees, who have

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\* The G.M.S.C. had "committed the sin of being too successful"<sup>986</sup>.

raised levies from general practitioners on behalf of the National Insurance Defence Trust and its successor the General Medical Services Defence Trust.\* Furthermore, meetings in the periphery showed quite clearly that the vast majority of ordinary general practitioners wished the L.M.C./Conference/G.M.S.C. structure to provide their leadership, and not the Representative Body<sup>1020, 1021, 1022</sup>.

The Conference and the G.M.S.C. however realised that they needed the cachet and resources of the B.M.A., and that an independent organisation would probably be less efficient and influential. The members of the B.M.A. also realised that any attempt to reduce or abolish the power of the G.M.S.C. would lead to secession, with the possibility of a crippling loss of membership from the Association. The replacement of the "myth of autonomy" \*\* by "delegated responsibility" at the Conference<sup>998</sup> and the unemotional

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\*The trustees of both Trusts are the members for the time being of the G.M.S.C. A short pamphlet on the Trusts, whose assets in 1972 were almost £1,000,000<sup>1077</sup> was written in 1969 by Dr. J.E. Miller, deputy treasurer of the Trusts<sup>1078</sup>.

\*\* These words were used by the proposer during the debate at the Conference. Thirteen years earlier Eckstein had referred to "the mythical autonomy" of the G.M.S.C. as a useful pretence<sup>1048</sup>.

reversal of "Chambers in principle" by the Representative Body<sup>1034</sup> has left the way open for a further study of the autonomy issue.\*

A new attempt at constitutional reform

The events of 1973 committed all the medico-political leaders to the finding of a solution to the problem which has faced doctors for sixty years; how to coordinate the activities of the Conference and its executive, representing all general practitioners in contract with the State, and the Representative Body and its executive, representing all members of the B.M.A. At the time of writing a new Working Party, chaired by the Chairman of Council and including influential members of the main committees and the Council, is attempting to do this, in an atmosphere of hope and urgency, whilst the memory of the Chambers crisis is fresh in their minds. Their success or failure will depend on whether or not their proposals reflect the wishes of the profession and provide the guidance and leadership needed in the rapidly changing circumstances of National Health Service practice.

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\* Rudolph Klein, an eminent sociologist,<sup>1079</sup> saw the decision taken at Folkestone as a notable victory for the leadership of the general practitioners, which it was. He did not comment on the fact that the Chairman of the Central Committee for Hospital Medical Staffs (successor to the C.C. & S.C.), the Chairman of the Hospital Junior Staffs Group Council, and other influential senior and junior hospital doctors had helped to secure "the victory".<sup>1030</sup>

APPENDIX 1.

Memorandum for the assistance of Divisions in the matter  
of the formation of Provisional Local Medical Committees.

Document D 46 (1912/13).

D-138

# British Medical Association.

## NATIONAL INSURANCE ACT.

### MEMORANDUM

for the assistance of Divisions in the matter of the formation of Provisional Local Medical Committees.

1. The Special Representative Meeting, February, 1912, passed the following resolution:—

*Minute 63.*—Resolved: That the Council be instructed to make all necessary arrangements for assisting the Divisions and Branches in the appointment of Provisional Medical Committees in every insurance area, to safeguard the interests of the profession, without prejudice to the question of whether these Committees shall later accept recognition as statutory local Medical Committees.

2. The State Sickness Insurance Committee, acting on behalf of the Council, has carefully considered this resolution, and now urges every Division to take steps to carry it out by appointing forthwith for the area of the Division, a Provisional Medical Committee to safeguard the interests of the profession.

3. It appears to the Committee to be of the utmost importance that in the formation and guidance of any Provisional Committee set up, the Association should take a predominant part, and, therefore, that the machinery of the Divisions should be made use of. To attempt at present to set up Provisional Committees in all the proposed Insurance areas, while still using the machinery of the Divisions, might be productive of great confusion and delay, because the respective areas are in many cases not co-terminous. It has, therefore, been decided to ask every Division to proceed at once to form a Provisional Medical Committee in its own area, without any present reference to the Insurance areas. In this way, the country will be covered by Committees set up with the sole purpose of organising the profession in regard to the Insurance Act; the machinery of the Association can easily be brought to bear on the situation; and the problem of electing statutory local Medical Committees, if the Association decides later to take part in working the Act, can be dealt with subsequently.

### MODE OF ELECTION OF PROVISIONAL MEDICAL COMMITTEES.

4. It is not desired to lay down hard and fast rules to govern the mode of election of these Committees, because local circumstances differ so widely. Where the Division is a fairly compact one the Committee may well be elected at a meeting of the profession. In this case, of course, all members of the profession should be invited, and special efforts should be made to induce non-members of the Association to attend. If it is thought desirable, the election may be conducted by a postal vote. But if the latter method is adopted, a meeting should be called previous to the election, in order that such questions as the size of the Committee, the proportion of Members of the Association to non-members on the Committee, and the general duties of the Committee, may be discussed. It may be convenient, and would help to secure the predominant position of the Association on the Committee, if the Executive of the Division were taken as the nucleus of the Committee to which representatives of non-members were subsequently added.



5. It is most desirable that every class of practice in the district should be represented on the Committee, as the question of the organisation of the profession against the dangers which threaten it is one for the whole of the profession. It is particularly important to have representation of consultants and members of hospital staffs, as their co-operation will be essential if the Act is to be fought. If the area is a scattered one, provision should be made that the various districts shall be represented on the Committee, the local representatives being regarded as specially watching the interests of the profession in their districts. It is not desirable that the Committees should be too large, but the size will depend on the nature of the district. In a scattered district where various localities need representation the number would need to be larger than in a compact Division. A definite proportion of the Committee should be allotted to non-members of the Association. It is suggested that the total number of the Committee should bear a stated proportion to the number of the profession in the area, and might range from 10 per cent. in a Division of one hundred or over, to 20 per cent. in a smaller Division.

6. If the area of the Division should lie in two or more Insurance areas, it would be an advantage to elect on the Provisional Committee a number, in proportion to the medical population, from each separate area, and the members from each separate area might, if thought proper, be elected by the practitioners in that area alone, and might form Sub-Committees for the respective areas.

#### MEETINGS OF THE COMMITTEE AND OF THE PROFESSION.

7. The Meetings of the Committee should be held at regular intervals to report progress. At intervals the whole of the local profession should be called together because the Committee must be assured, from time to time, that it continues to represent the views and has the loyal support of the whole local profession.

#### WORK OF THE COMMITTEE.

##### (A) *General.*

8. The work which lies before each Provisional Medical Committee is to so organise the profession that whatever happens it may be ready. It is the safest plan to prepare for the worst, and the worst will probably be an attempt by the Commissioners or Insurance Committees, having failed to meet the demands of the profession, to hand the money provided for medical benefit over to the Approved Societies and allow them to make the medical arrangements. In such a case the temptation offered to the doctors who at present hold Friendly Society appointments would be great, and one of the first and most important duties of the Provisional Committee will be to ascertain the views of the club doctors in the locality, and to make sure of their loyalty. There certainly will be a temptation to accept an increase of work, and possibly of remuneration, which so far as the latter is concerned might probably only be temporary. If any considerable number of the profession gave way to this temptation the chance of greatly modifying, if not ending, the control of the profession by the Friendly Societies, would be lost, probably for ever. The terms of the Undertaking already signed by the overwhelming majority of the profession are such that those who have signed are in honour bound to refuse to make any arrangements whatever as regards medical attendance on insured persons, except through their local Medical Committee. The first business of the Committee will be to satisfy itself and the Association that they can depend upon all the local doctors, and particularly the club doctors, taking this line. It will follow that the club doctors must in their turn be assured of the loyal support of the rest of the local profession.

##### (B) *New Members of Association.*

9. Strong efforts should be made to obtain additional members of the Association. The Association is bearing the responsibility of this campaign, and it is only fair that the profession generally should be made to realise that they can and ought to support it with all their might. That non-members can do so most effectively by coming into its ranks.

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(c) *Local List of Contract Practice Doctors.*

10. A complete list should be obtained, in each district, of those engaged in contract practice. This it has been found impossible to do centrally, the returns given in the signed undertakings being very incomplete. It can only be done properly by a personal canvas in each district. The information is practically essential to proper organisation and should be obtained without delay. The list should include every club held by every member of the profession in the district of the Committee.

(d) *Individual Canvass of Local Profession in regard to Local Campaign.*

11. Each Provisional Medical Committee should set itself to obtain:—

(i.) from practitioners at present engaged in contract practice, an undertaking that they will decline to receive insured persons into their clubs on terms other than those acceptable to the Committee, and also to pledge themselves to place their resignations of such clubs in the hands of the Committee for use as and when required. A form of bond for this purpose is being prepared.

(ii.) from all practitioners, an undertaking to refrain from applying for or accepting any post vacant in consequence of the resignation (when proffered at the request of the Committee) of the present medical officer; also to decline to accept on their list of insurance patients, for the first six months after medical benefit is in force (if this is administered on terms approved by the Association) any persons previously members of a club, if the present medical officer signifies his wish to retain them.

(iii.) from all practitioners a guarantee of as much as they can afford to the Insurance Defence Fund, either Central or Local. If no local fund has up to the present been formed, it is strongly advised that no such fund be formed and that the guarantee be made to the Central Fund, as this is a much more simple procedure from the point of view of book keeping, and the money can be directed from such a fund to the district where it is most needed. In view of statements which have been made, the Provisional Committees would do well to inform practitioners that the Association has been assured on high legal authority that there is no difficulty in the way of the Council of the Association administering such a voluntary fund or devoting it to the compensation of practitioners who need such compensation. The possession of a large fund would do more to reassure those practitioners who fear that a fight with the Friendly Societies would seriously injure them, than any other thing which it is within the power of the profession to do. The profession could raise, with the greatest ease, a guarantee fund of £250,000, and a great deal more if required, and would then, undoubtedly, be in a position to support practitioners who were proved to have suffered loss by loyalty to the policy of the Association. There are few members of the Association who would not guarantee £5, knowing that the payment of this sum will be spread probably over three or four years, that it will be called up in small sums proportionate to the amount of the guarantee, and that probably most of it may not in fact be required. It must be remembered that no money can be required, except for administrative purposes, until the Act has been in force for some time and actual loss shewn to have been incurred. The great majority of practitioners could easily afford to guarantee more than £5, and will do so if once they realise that this is a great crisis in the history of the profession which demands self-sacrifice and determination.

12. There are many other points in the plan of campaign which the Provisional Committees have to deal with, but these may be left for a further circular. It is most important that the Committees should be formed without delay and in such a way as will make them thoroughly

representative of the local profession, and that they should at once set about (a) finding out how many local practitioners are engaged in contract practice work, and to what extent, (b) ascertaining their attitude and making sure of their loyalty to the policy of the Association, (c) raising funds, (d) getting every possible member of the profession into the Association.

#### EXPENSES OF THE COMMITTEE.

13. It has been decided that the expenses of the Committee shall be defrayed out of the Central Defence Fund, or, if a local Defence Fund exists, out of the latter fund. A special account should be kept, separate from the ordinary Division account, and where a Local Fund does not exist a statement should be sent up from time to time to the Head Office, when the expenses will be defrayed. It must be clearly understood that unless local exceptional conditions can be shown to exist, expenses will only be defrayed from the Central Fund when the practitioners of the district have shown their willingness to support that fund.

#### CO-ORDINATION OF THE WORK OF PROVISIONAL MEDICAL COMMITTEES.

14. It is suggested that in order to co-ordinate the work of the Provisional Medical Committees, and in order still further to keep them in touch with the Association, all the Committees in the area of any Branch shall agree to recognise the Council of that Branch as the co-ordinating body for that area. Reports of progress should be made from time to time to the Branch Council, and it should be agreed by resolution that the Provisional Medical Committee shall enter into no dealings with any authorities under the Insurance Act until they have received the sanction of the Branch Council for so doing.

15. The Branch Councils will, in their turn, be responsible to the Council of the Association, and should agree by resolution that the Branch Council shall not accord its sanction for any Provisional Committee to enter into negotiations with any Insurance Authority until it has received the sanction of the Council of the Association for so doing.

16. In this way it will be easy for the Association to carry out the policy adopted by the Special Representative Meeting in November, 1911, namely, "that no arrangements for attendance on insured persons be completed anywhere until the Association is assured, by reports from the local Medical Committees, that terms in conformity with the policy of the Association in detail have been agreed upon everywhere."

#### ASSISTANCE FROM HEAD QUARTERS.

17. In carrying out the instructions given above, the Divisions can rely upon the utmost assistance being given by the Council of the Association, the State Sickness Insurance Committee and the Head Office. It may be found necessary in order to arouse the enthusiasm and determination of the profession in certain districts to hold mass Meetings, and every effort will be made to supply such Meetings with speakers if desired. In offering this assistance, the State Sickness Insurance Committee confidently calls upon the Divisions to show by active organisation that the profession will not content itself with protestations but is prepared for work and, if necessary, for sacrifice.

APPENDIX 2.

A Charter for the Family Doctor Service, 1965.

G.M.S.Voice dated March 18 1965.

## BRITISH MEDICAL ASSOCIATION

# A CHARTER FOR THE FAMILY DOCTOR SERVICE

We set out in these pages what we believe to be the basic needs for a good family doctor service.

To give the best service to his patients, the family doctor must —

Have adequate time for every patient.

Be able to keep up-to-date.

Have complete clinical freedom.

Have adequate well-equipped premises.

Have at his disposal all the diagnostic aids, social services and ancillary help he needs.

Be encouraged to acquire additional skills and experience in special fields.

Be adequately paid by a method acceptable to him which encourages him to do his best for his patients.

Have a working day which leaves him time for some leisure.

If these conditions are met, and they are by no means met at present, a harmonious relationship between doctors and patients will be assured.

To achieve all this, we have arrived at the following conclusions which are elaborated in this document:

- (i) The family doctor service is breaking down. While there is a rising population there is at the same time a growing shortage of doctors. Moreover there is a growing demand on the doctor's services by each patient. The only effective long term solution is more general practitioners. This means more medical schools and making conditions in general practice attractive to new entrants. All medical schools should include Departments of General Practice which should also organise vocational postgraduate training.
- (ii) As an immediate measure, every step must be taken to husband the doctor's skills so that they are put to the most effective use.  
This means:
  - (a) more ancillary staff
  - (b) modernised and improved premises and equipment
  - (c) eliminating work which wastes the doctor's time (e.g. certification)
- (iii) General practice must remain a personal family doctor service.

(iv) An independent corporation should be set up with adequate public funds to finance the purchase and modernisation of premises and equipment.

(v) A doctor's pay must be related directly and realistically to his work load and responsibility. It must also be sufficient to attract and retain an adequate number of doctors to general practice. Without depriving the patient of necessary medical attention at all times pay must be based, as it is for other members of the community, on a reasonable working day and week, with time for study and leisure.

(vi) There must be a reduction in the excessive number of patients for whom many doctors have to care. As more doctors enter general practice, the maximum size of lists will be progressively reduced. Lists must be reduced only by stages and in consultation with the profession, so that doctor's incomes can be safeguarded to meet the increasing demands on their services. It is difficult to predict, but we would not regard a maximum list of 2,000 as an unreasonable target.

(vii) The method of payment must be flexible. Groups of family doctors should be given a choice of payment by capitation fee, item of service or some form of salary. But all three methods must be based on our recommended fees for a consultation at the doctor's surgery or visit to the patient's home.

(viii) A doctor's pay should include normal practice expenses, save that to encourage the increasing use of ancillary staff and the provision of improved premises and equipment, direct reimbursement must be made for expenditure on these items.

(ix) The whole range of disciplinary machinery needs complete overhaul.

These reforms are drastic. Inevitably they are costly, because of the neglect and mistakes of the past. If general practice is to stay a worthwhile branch of medicine it must enable doctors to use their skills to the best advantage of their patients. It must also ensure that their energies are not wasted on work that can be done by others.

We are confident that these recommendations would give the public the best service possible, and lay a firm foundation to meet the needs of the community in the future.



## The Doctors' Day

Good family doctors are not created by the structure of a National Health Service. But the structure can — and should — enable doctors to keep abreast of modern developments and techniques and have the opportunity to practise them. It should also ensure that their mental and physical health are not impaired by the long hours worked at present.

We therefore recommend that the family doctor's contractual obligation should be limited to:

- (1) a reasonable working day. (We see no reason to perpetuate the anachronism of late evening surgeries.)
- (2) a 5½ day working week.
- (3) 46 weeks in the year.

This would give every family doctor sufficient time for postgraduate education and leisure.

The public rightly expects to be able to obtain medical attention whenever it is needed. Doctors accept the moral responsibility to provide it. But the increasing difficulty of fulfilling this obligation personally is illustrated by the development in recent years of weekend and night rota schemes, emergency deputising services and the like. The public has recognised this by accepting these schemes.

Many family doctors will wish to continue to provide services to the limit of their capacity. But they must be relieved of the contractual obligation of never-ending responsibility. Every doctor must, so far as his area of practice allows, be free to exercise an option in this matter and to accept or refuse continuous responsibility. The onus of making arrangements for out-of-hours medical attention must rest on the Government. The additional work load of those who choose (or are compelled by circumstances) to offer their services outside the normal working day must be properly remunerated.

It is not in the interest of the patients that any doctor should have to care for a list of 3,000 or over. Every year 400 doctors emigrate, and the work load of those remaining is steadily increasing.

## Scope of the Doctor's Work

We see no reason to change the definition of the scope of a family doctor's work, with the one exception of certification.

This is by general consent one of the most time-wasting of the family doctor's tasks, particularly in the present era of overwork and shortage of doctors. Employing clinicians, whose services are in such demand, on clerical and administrative duties of this kind cannot be justified. The whole range of medical certification requires urgent reform. But the first immediate step must be to reduce to a minimum the burden of certification for National Insurance purposes. It is not for us to suggest alternative arrangements. Our concern is with the benefit to the public which will result from releasing the doctor's time in order to attend to his patient's medical needs.

We must however refer to the existing isolation of the family doctor from other parts of the National Health Service. Modern medicine requires the family doctor to play his full part in an integrated service. The day of the doctor working in isolation is over.

Though the position of the single handed practitioner must be preserved, nevertheless we favour the encouragement of group practice where this is possible.

Successive Governments have agreed that family doctors should have access to the full range of diagnostic services. Some progress has been made, but not enough. The Government must also give priority to allocating an adequate number of hospital beds for general practitioners. The full range of social and preventive services must also be available to the family doctor.

Furthermore we think it desirable that doctors should be given a positive inducement to acquire additional skills and experience in special fields.

## Practice Premises

The family doctor needs comfortable, convenient and up-to-date premises to provide the standard of service that he would wish to give the public. One of the most difficult problems of many family doctors, and particularly of new entrants to general practice, is to raise the capital needed to acquire or modernise premises, and to repay out of income capital borrowed for this purpose. The Government recognised 20 years ago the impossibility of relying on private resources to build new premises and modernise the old. Millions of pounds of public money have rightly been spent on hospitals — but virtually nothing on general practice. The individual doctor has been left to finance a national family doctor service with the aid of commercial resources. This will no longer do. The Government should act as banker and provide capital on terms that will give the family doctor an incentive to use it, instead of the disincentive that exists today.

We recommend that an independent corporation financed from public sources should be set up. This corporation, with appropriate professional representation on its Board, would operate in various ways according to the requirements of the individual doctor or group of doctors, and the needs of his or their area of practice. It would:—

- (i) Lend money for purchasing or improving any surgery premises repayable over long periods (we visualise that these could be calculated on the borrowing doctor's expected professional life). The money lent by the corporation for improvements would be the balance over and above the present improvement grants.
- (ii) Acquire surgery premises, and lease or sell them to family doctors as preferred.
- (iii) Build and lease to family doctors purpose-built premises.
- (iv) Help to provide medical and practice equipment.

## Other Matters affecting the Doctor's Terms of Service

### Disciplinary Machinery

The present disciplinary machinery for hearing complaints and the punitive measures taken against doctors have come under much criticism. There must be a drastic overhaul.

### Dispensing

Every rural family doctor should be free to dispense for his patients if he so wishes and remain free to do so.

### Inducements

- (a) The inducements in rural areas should continue and the recently introduced rural practices scheme (including the Rural Practice Fund) should be given a period of trial before review.
- (b) It is essential that the Government should provide greater inducements in under-doctored and special areas. We favour such a method rather than any form of direction of doctors.

### Terms of Service

All the Terms of Service and the highly complex Regulations which surround them need complete re-casting. This includes the present unsatisfactory Allocation Scheme.

### Superannuation

The implementation of our new pay proposals which follow will necessitate a complete revision of the family doctors' Superannuation Scheme and the elimination of the defects of the present scheme. We wish, however, to emphasise that the doctor should be free to make additional contributions to increase the benefits to his dependants.

### Compensation

The compensation money for loss of the right to sell the goodwill of practices, which has already fallen so much in value, should be payable when the doctor reaches the age of 60, or completes 20 year's service, whichever is the sooner. The present inadequate rate of interest —  $2\frac{1}{4}\%$  — should be brought into line with modern rates.

### Responsibility for actions by deputies

Existing regulations stipulate that a G.P. principal is responsible for the acts and omissions of his deputy unless the latter is on an Executive Council list. This is inequitable and must be put right. Any qualified doctor should be required to accept full responsibility for his own actions.

## Method of Payment

There has been rising discontent with the Pool method of payment. It is based on the twin concept of a pre-determined guaranteed net average annual income, and an estimate (based upon a sample statistical survey) of the aggregate of expenses incurred by all general practitioners. This is unjust because:

- (1) It is unreasonable to limit net remuneration when there is no limitation of either hours or volume of work done.
- (2) The distribution of such a pool through capitation and loading fees means that the expenses received by the individual doctor are unrelated to his actual expenditure. Certain elements vary considerably from one doctor to another. The injustice of this system of payment has been fully demonstrated in the recent awards of the Review Body.

It is essential that the Government should agree with the profession a basis of payment which realistically and directly relates a doctor's income to his work load, responsibility and expenses incurred.

This can best be done by constructing an entirely new system of remuneration, based on the fees which a family doctor can reasonably expect to earn for surgery consultations and visits to the patient's home. The Government has already

accepted certain rates of pay for services comparable with those with which we are now concerned. These fees are the starting point for our own calculation.

The fees we have in mind are as follows:—

#### (a) Fees Approved by the Ministry of Defence for Payment to Admiralty Surgeons and Agents

- (a) For consultation by a patient at the doctor's house or surgery excluding drugs and medicines other than minor surgical dressings .. .. . 10s.
- (b) For a visit by the doctor to patients at their own homes. In respect of each patient seen by day, 15s. by night (8 p.m. to 9 a.m.) .. .. . £1

These fees are increased by mileage at the rate of 1s. per mile each way beyond a radius of two miles from the doctor's residence.

#### (b) Whitley C. Agreement

Fee for emergency visit to local authority establishment, e.g. children's homes, special schools, boarding homes, hostels, etc.

Fee for emergency visit to establishment,

By day .. .. .	£1 2s. 6d.
By night .. .. .	£2 5s. 0d.

#### (c) Treasury Agreement

For part-time medical services to Government Departments outside the National Health Service.

For any visit of up to one hour's duration,

By day .. .. .	£1 15s. 0d.
By night .. .. .	£3 10s. 0d.

All these fees came into operation on April 1, 1963, and are shortly due for review. We have deliberately chosen the lowest scale of fees approved by the Treasury, namely those set out above under the Ministry of Defence schedule. But we have increased these fees by an arbitrary figure of 10% to represent changes in the value of money and in the cost of living since April 1, 1963. For the purposes of our calculations we have assumed, on sound authority, confirmed by recent Ministry of Health surveys —

- (i) The figure of 5 consultations per patient on the doctor's list per year, as the average for Great Britain as a whole.
- (ii) A surgery: domiciliary consultation of 2.5 : 1.

We have adjusted our calculation of a proper capitation fee, based upon these statistics, to allow for the fact that the new contract will cover —

- (i) a 46 week year
- (ii) a  $5\frac{1}{2}$  day week
- (iii) a separate payment on an item of service basis for night work and weekend consultation.

We have made further adjustments to take account of the reduction in work load at the doctor's surgery which should result from our proposals to reduce the volume of certification for National Health Insurance purposes. We have also taken account of our proposal that in future the full cost of employing ancillary help, and of providing, as distinct from maintaining, surgery premises (e.g. heating, lighting, etc.) should be directly reimbursed. If these adjustments were not

made, and if we had calculated on the basis of an average 5 consultations per patient per year and an A/V ratio of 2.5 to 1, the appropriate capitation fee would be 62/8. Application of all these factors results in a capitation fee which we estimate to be approximately 36/- on the assumption that our proposals on certification are accepted.

We intend that payments by capitation at the level of 36/- per patient per year should be supplemented by additional payments for night and weekend work. These additional payments should be calculated on an item of service basis, using the Ministry of Defence scale with an additional 10%, to allow for the fall in the value of money and increased cost of living since April, 1, 1963, i.e. £1 2s. 0d. per home visit and 11/- per surgery consultation. When a doctor is on holiday or absent from his practice through illness, or for postgraduate education, his patients would be cared for by other doctors—locums or colleagues—who should be paid on the same basis as that of temporary residents or on an item of service payment.

Like the examples we have given these recommendations include an element to cover practice expenses.

The evidence gathered by the Association for the Fraser Working Party suggests that the majority of family doctors wish to keep the capitation fee method of payment. But this evidence also suggests that a by no means inconsiderable number of doctors favour payment by item of service. Others, a smaller number, favour payment by some form of salary. We see no reason why any one system should be imposed to the exclusion of others. Since the National Health Service began there has been too little flexibility in the method of paying family doctors. We believe each group of doctors should be allowed to choose the method by which they are paid. However, if this is done, the level of payment in each system must be based upon the professional fees which we have indicated as reasonable for surgery consultations and home visits.

## Capitation Fees and Expenses

Although the profession has shown it wants a direct reimbursement of all practice expenses, we are satisfied that this could be achieved only at the cost of irksome and oppressive controls. A capitation system must embrace within it all practice expenses except ancillary help and provision of practice premises. This is not incompatible with our desire to relate income directly to work load, responsibility and expenses incurred by the individual doctor. For with the exception of the expenses borne in employing ancillary help and providing practice premises, there is no substantial variation from doctor to doctor in the other items of expenditure essential to the conduct of general medical practice.

The present method of reimbursing practice expenses has been condemned by both Government and profession as unjust. More than anything else, it has militated against the

improvements needed to obtain the best family doctor service. We have accepted in an earlier paragraph that capitation fees are gross, in the sense that they embrace all expenses, other than those incurred in connection with the employment of ancillary help and provision of practice premises. The capitation fee we have recommended above has been adjusted to exclude such expenses.

We propose that there should be direct, full, and prompt reimbursement of all expenditure on ancillary help. We accept that this would mean an upper limit, to be agreed between the profession and the Health Departments from time to time, on these payments.

## Practice Premises

Whereas expenses incurred in providing ancillary help have hitherto been reflected globally in the expenses element of the Pool, there have never been any defined payments directly related to the cost of providing practice premises, as distinct from maintaining them. The Review Body in its 5th Report recognised this fact, and suggested that there should be discussion between the health departments and the profession with the object of correcting this anomaly. We recommend:—

- (1) That in the case of surgery premises which are rented, there should be full, prompt and direct reimbursement of the rent and associated rates.
- (2) That in the case of owner-occupied surgery premises, there should be similar direct reimbursement of a notional rent, to be determined by some independent professional valuer.

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All the above recommendations refer only to payment for general medical services. All other services provided by family doctors will be paid for additionally at rates to be negotiated and regularly reviewed. We have particularly in mind such important services as maternity, ophthalmology and the like.

We must emphasise that the detailed pricing of the new contract we have in mind must be first agreed direct between the profession and the Government.

What we propose goes far beyond the adjustment of existing levels of remuneration. A fresh start is needed. We would hope, however, that thereafter periodic adjustments will continue to be undertaken by the Review Body, possibly with some modifications of their remit. In any event we strongly recommend that the new contract be reviewed at regular intervals in all its aspects.

We believe that these proposed arrangements would provide a great stimulus to better general medical practice which it is the Ministers' duty to provide. Coupled with our other recommendations for providing capital, they lay down a firm basis on which we can confidently build the general practice of the future.

B.M.A. HOUSE,  
TAVISTOCK SQUARE,  
LONDON, W.C.1.

March 8, 1965.



Issued by the GENERAL MEDICAL SERVICES COMMITTEE for Family Doctors practising in the National Health Service.

## THE MINISTER REPLIES TO THE CHARTER

Since the last issue, much has happened. The Review Body was asked to explain parts of its award. As a result the £5½ million is to be distributed by increasing both capitation and temporary resident fees to 22s. 6d. from April 1st.

The way was then open to negotiate with the Minister of Health for an entirely new family doctor contract, with a completely new method of payment.

On March 8th the Minister received the Charter for the Family Doctor Service. This had been drafted from the mass of submissions received from general practitioners. It had received unanimous approval from the G.M.S. Committee and the Council.

Along with all other general practitioners you will have received a copy of this Charter setting out the reforms necessary for a good family doctor service. With the concept of a reasonable day's work was the proposal that payment should be realistically related to the fees which a family doctor could expect to earn for each individual consultation. There were in addition reforms and remedies proposed for the majority of the causes of discontent within the existing family doctor service. One of the most original proposals was the setting up of an independent corporation, financed from public funds, to help family doctors to purchase or lease suitable premises.

The Charter received considerable support from public and press.

On March 24th a Special Joint Conference of L.M.C. and B.M.A. representatives is to decide whether adequate progress has been made towards a new contract, and whether or not to take the final step of inviting the British Medical Guild to deliver the resignations held to the Executive Councils, to take effect from July 1st. The number of undated resignations received by the Guild was over 16700 on March 18th.

The Minister wrote on March 16th, expressing his views on the Charter. His letter will be one of the documents on which the Joint Conference will base its decision on March 24th. It was considered by the G.M.S. Committee and by the Council on March 17th. Both the Minister's reply and the decisions taken are set out overleaf.

The Minister's letter makes it clear that he had only eight days to examine the very detailed Charter. Our representatives met the Minister almost daily during this period. It was evident that all the proposals were drastic, some involving changes of legislation. Therefore in his letter the Minister has put on record only his preliminary reactions.

The Minister agrees that our proposals for a new type of contract seem to provide a perfectly possible framework for negotiation. He is prepared to negotiate on every single matter in the Charter apart from the level of remuneration. He states that he accepts the need to help doctors with the provision of finance for practice premises, and will discuss our suggestion for a separate publicly financed corporation. And finally overall, he thinks the Charter provides a framework for negotiation, for example, on direct reimbursement of the cost of ancillary help and rent of premises, measures to try to bring about a significant reduction in certification, revision of the Terms of Service, and the disciplinary machinery — a formidable catalogue.

Also included in the Charter were changes in compensation and superannuation though they are not mentioned by the Minister in his letter.

But on remuneration, though he is prepared to envisage alternative methods, he considers that pricing of the new contract must be a

### From the Chairman to You

Please give most careful study to the Minister's reply to the proposals contained in our Charter.

I should explain that the Minister had only eight days in which to consider it and in that time it was not possible to settle, nor were we in a position to commit the profession, on matters of detail affecting our proposals. It was, however, possible in that time to obtain an assurance from the Government that it would accept our Charter as a basis for negotiation. This represents some progress.

The General Medical Services Committee feels that it would be wrong to advise family doctors to authorise the Guild to submit their resignations now in face of this offer to negotiate a new contract. But the Minister's reply is couched in vague and general terms. It is essential that we should test the Government's real intent before making the final decision. We have therefore selected one or two important issues in our Charter on which we believe the Minister could — if he so wished — give us prompt assurances and on which we could make real progress.

There remains the issue of remuneration. The Government has said that it cannot provide additional pay for doctors save on the advice of the independent Review Body. I wish to emphasise that we cannot possibly accept this declaration unless we are able to obtain assurances on the terms under which the contract will be priced. We have therefore included this matter as one of the essential points which must be cleared before the three months' period has elapsed.

Finally, I want to stress that we are not departing in any way from the fundamental points laid down in our Charter. I want to give you my personal assurance that we are recommending the deferment in order to give the Minister one final chance to show the Government's real intent. But it must be the final chance. If these assurances are not received, withdrawal from the Service on July 1st will be inevitable.

matter for the Review Body. He concedes that no agreement has been reached on the method of pricing.

Thus there is an offer to negotiate and discuss the Charter in general. But what this will amount to is by no means clear. It is the view of the General Medical Services Committee and the Council that the Minister's intention should be tested by seeking assurances on three specific points in the Charter within a definite short period of time. He must also agree terms which are acceptable to the profession, under which he proposes to refer the pricing of the contract to the Review Body.

If in this short interval the Minister continues to make unspecific promises and does not guarantee that the system of remuneration is to be completely recast — and the Review Body advised of this — then obviously no progress can be made. And the N.H.S. will be no place for the family doctor.

## THE MINISTER'S REPLY TO THE CHARTER

MINISTRY OF HEALTH,  
ALEXANDER FLEMING HOUSE,  
ELEPHANT AND CASTLE,  
LONDON, S.E.1.

16 March, 1965.

DEAR DR. CAMERON,

We have agreed that the £5½ million increase in remuneration recommended by the Review Body should be added unconditionally to the Pool and in accordance with your wishes it is to be distributed by increasing the capitation fee (at present 20s. 6d.) and the temporary resident fee (at present 21s.) to 22s. 6d. General practitioners will be receiving this increase in their net remuneration with effect from 1st April, 1965.

I am now writing, on behalf of the Secretary of State for Scotland and myself, in the light of our discussions in the last few days, to put on record my preliminary general reactions to the very far-reaching proposals in the "Family Doctors' Charter" which you presented to me only on 8th March. You will agree that this has given me very little time to consider in detail proposals for fundamental changes in arrangements which have stood for nearly 17 years.

It has been repeatedly stated that what is now needed in general practice more than anything else is a revision of general practitioners' terms of service and methods of remuneration. I have told you that your proposals for a new type of contract and flexibility in methods of remuneration seem to me to provide a perfectly possible framework for negotiation. During the course of negotiation I shall want to inject ideas of my own, but I believe that the Charter offers an opportunity, which we should all do well to seize, to improve the general practitioner service for doctor and patient alike.

I was at first concerned lest the proposal for limited liability for the individual doctor and a review of the Allocation Scheme implied a repudiation of the liability of the profession as a whole for the general medical care of the population as a whole, with continuous cover, but you have assured me that this is not so, subject to reasonable protection of the individual doctor against unreasonable demands on his services. On this basis I am prepared to discuss limitation of individual liability.

Perhaps I should deal first with the question of remuneration for services rendered under the new contract. I am prepared in principle to envisage alternative methods of remuneration according to circumstances, provided that suitable safeguards can be devised. As to the amount to be paid, by whatever method is applicable, we have an independent Review Body to advise on remuneration, and while I am content that the Government should discuss methods of remuneration direct with the profession, I am sure that we must continue to look to the Review Body for advice on levels of remuneration. The Review Body was set up with the profession's agreement because the Royal Commission which reported in 1960 thought it "highly desirable in the interests of efficiency, good relations and mutual confidence to introduce some new machinery in place of direct negotiations for dealing with important financial

changes", and a change on the introduction of a new form of contract is certainly important. I have suggested that the negotiation of the new contract will produce an entirely new situation for the Review Body to consider. In considering this situation, it will be open to the Review Body to take account of any method or combination of methods of assessing levels of remuneration which is put before them by the profession. We have so far been unable to reach a conclusion between us on how this matter of pricing a new contract should be handled.

My position is that, provided it is understood that I should not be ready to agree to new levels of remuneration except on the recommendation of the Review Body, I am prepared to negotiate on all the other matters covered by the Charter, and I believe that it would be in everyone's interest that we should do so.

One of the suggestions in the Charter, for example, is that public finance should be made available for the provision of practice premises. I am interested in any idea likely to improve general practice and I should be very ready to consider with the profession how premises for practice can be provided in a manner most likely to bring maximum benefit to doctors and patients alike. I accept the need to help doctors with the provision of finance for practice premises, and I am prepared to discuss with you your particular suggestion for a separate publicly financed corporation, though, as I have explained to you, this would require legislation.

I entirely agree of course that family doctors should have access to proper diagnostic services and to hospital beds where appropriate, also that they should be able to work in concert with social and preventive services. I see all this as part of the development of general practice along lines that accord best with local needs.

For the rest also I think the Charter provides a framework for negotiation, for example on direct reimbursement of expenses on ancillary help and rent of premises, measures to try to bring about a significant reduction in certification, and revision of the Terms of Service and the disciplinary machinery.

I have therefore suggested that we should now get down to detailed discussions on a new type of contract and new methods of remuneration, the provision of practice premises and the rest of the Charter apart from levels of remuneration, since those matters must be settled before levels of remuneration can be fixed and I hope we can reach agreement upon them.

These discussions are bound to take time, notwithstanding everyone's best endeavours, and I do not see how new arrangements could in any event be brought into effect before the end of the period for which the Review Body's recommendations in 1963 were intended to last. With good will on both sides I should hope we could have a new and priced contract ready to introduce then. Our joint aim must be to secure for the general practitioner the conditions he requires to give the best care to his patients and the greatest satisfaction to himself.

Yours sincerely,

(Signed) KENNETH ROBINSON.

The G.M.S. Committee's recommendations are opposite

## THE G.M.S. COMMITTEE'S RECOMMENDATIONS — APPROVED BY THE COUNCIL OF THE B.M.A.

- (1) In the Committee's view the progress made in exploratory discussions with the Minister of Health on the Charter for the Family Doctor Service is not such as to justify advising the British Medical Guild to return the undated resignations which it holds to the practitioners concerned. On the contrary the Committee is more than ever convinced that the future of the family doctor service depends upon the profession maintaining its unity and determination until the present crisis in general practice is successfully resolved. It therefore invites the British Medical Guild to redouble its efforts to ensure the maximum possible unity in the profession.
  - (2) Nevertheless, bearing in mind the terms of the Minister's letter, and in particular his stated belief "that the Charter offers an opportunity, which we should all do well to seize, to improve the general practitioner service for doctor and patient alike", and that "the Charter provides a framework for negotiation" it is the Committee's view that more time should be allowed to test in detail the Government's intent.
  - (3) The Committee appreciates that some of the proposals in its Charter involve amending legislation. It therefore realises that it may not be possible to effect a new contract, in all its detail, before the beginning of the financial year 1966 - 67. It is, however, convinced that a much shorter time limit can be set to test the Government's intent on a limited number of the profession's proposals which could then serve as an indication of its probable attitude on the remainder.
  - (4) The Committee therefore recommends to the Joint Meeting on March 24th, that the British Medical Guild be advised to hold the resignations in its hands for a further period of three months, i.e. until June 30th, 1965, and that in that period the Minister be asked to give positive and unequivocal assurances on the following matters:
    - (a) A firm promise that the Government will introduce early legislation for the establishment of an independent corporation to finance the provision and improvement of practice premises where necessary, and to place adequate public monies at its disposal. This will be of great benefit to the public.
    - (b) That, in order to relieve the pressure on an under-doctored service and to improve the profession's service to the community, the Minister must (i) promptly make additional finance available on terms satisfactory to the profession for the employment of ancillary help; (ii) reduce the burden of certification.
    - (c) That if the pricing of the contract is to be referred to the Review Body, it must be on terms which ensure (i) that the Pool is abolished; (ii) that the assessment of professional remuneration shall be "ab initio"; (iii) that the basis can be applied to alternative methods of remuneration, e.g. capitation fee, item of service, some form of salary; (iv) that this particular reference will neither be restricted by the criteria established by the Royal Commission nor prejudiced by the considerations expressed in paragraphs 42 and 46 of the Review Body's Fifth report.
  - (5) If the assurances asked for in paragraph 4 (c) are obtained, which mean in effect, to use the Minister's own words "the negotiation of the new contract will produce an entirely new situation for the Review Body to consider", and if the Minister will so inform the Review Body, the Committee is prepared to advise the profession to leave it to that body to assess the justice of the figures set out in the Charter.
- The Committee sincerely believes that if firm and satisfactory assurances on the other straightforward matters referred to above cannot be secured within a period of three months, the profession will have no confidence in the outcome of discussions on the remaining items in the Charter. In these circumstances it would be in the best long-term interests of the public if general practitioners withdrew from the N.H.S. so that—in direct contract with their patients—the profession could itself shape and develop general practice for the benefit of the community.
- Unless firm assurances are received on these few issues the Committee sees no option but to advise the Guild to put in the resignations on July 1st.

# THE B.M.A. INSURANCE SCHEME FOR PRIVATE PRACTICE

When resignations become effective some patients will not be able to pay directly for medical attention and will need an insurance scheme. Many others will wish to avail themselves of such arrangements. The British Medical Association with the help of expert advisers has devised a scheme which will enable patients to assure continuing medical care direct with their family doctors. This scheme cannot be completed until representatives of Local Medical Committees, Divisions and Branches make their decision on the resignations held by the British Medical Guild.

An assurance can be given now to the profession that the project is sound and can be put into operation very soon after the decision is taken. The estimates in the scheme are based upon an expert statistical survey of the age and sex distribution of the population. Inevitably there is some variation in these statistics and consequently the income derived from any particular size of practice may vary from one area to another. There is no reason to believe that such variations will be considerable.

## An Outline of the Scheme

Some patients may subscribe to the existing G.P. schemes of the Provident Societies, but many others especially in urban areas will wish to join a scheme of this type.

The main objects have been:

- (1) To provide a general practitioner service to patients at moderate costs.
- (2) To assure the family doctor an adequate payment for his services.
- (3) To provide a simple scheme with minimal running costs.

The following is the scale of fees proposed:

	Per head per week
	s. d.
(i) Unmarried males under age 20 .. .. .	6
(ii) " " age not less than 20 and under 65	2 0
(iii) " " age 65 and over .. .. .	6
(iv) " females under age 20 .. .. .	6
(v) " " age not less than 20 and under 60	2 0
(vi) " " age 60 and over .. .. .	6
(vii) Married couples (male partner up to age 65) ..	2 0
(viii) " " (male partner over 65) .. .. .	6

Examples (a) A married couple when the male is under 65 pays a total 4/- per week. Where the male is over 65 and probably a pensioner they pay a total 1/- per week.

(b) A family of four consisting of two adults and two children would pay 5/- per week.

## The Estimated Gross Income

The gross income based on this scale in a full year's working with all the patients on an average list of 2,000 subscribing is likely to be: £134 9s. a week or £6,991 8s. a year if pensioners pay the charges shown.

If no charge is made to pensioners the income will be £127 11s 6d. a week or £6,633 18s. per annum.

The income from other lists would be in proportion. In a year on average 67% of those on a doctor's list consult him. Though it can be assumed that the majority would join the scheme, the gross income for the first year would probably be less than the figures quoted above. However there could also be fees from patients who preferred to pay for each consultation, obstetric cases, whether paid by the Executive Council or privately.

Where patients prefer to pay a consultation fee it should be a realistic figure to provide adequate remuneration for the work done.

## Collection of Premiums

The method of collecting premiums will vary according to the type of practice. Some patients may contribute through banker's order or by quarterly cheque. In industrial or urban areas a system of collection would need to be arranged. This could be done either by the practice itself or through an organisation in each district. The possibility of employing a national agency is being explored; the administrative costs including those of collecting premiums are unlikely to exceed 10% of the total.

Rural areas have special problems, collection of premiums, mileage, and dispensing. Special consideration is being given to these matters and it may be necessary for adult patients in rural areas to pay an extra 3d. a week. This would compensate for lower lists and higher mileage.

## Other Services

### Drugs

The scheme proposed above does not include the cost of drugs. The provision of a pharmaceutical service is an entirely separate duty imposed on the Minister by the National Health Service Act. Withdrawal of general practitioners from the N.H.S. should not affect this in any way. Nevertheless, if the Minister did withdraw the pharmaceutical services the premiums payable under the scheme now proposed could be easily adjusted by the addition of a further modest premium to cover the provision of the majority of drugs in general use. Premiums would need to be increased by about 9d. per week per patient if drugs were included. Sympathetic consideration would be given to old age pensioners. It is assumed that patients would obtain appliances through the hospitals as is the custom at present.

### Dispensing Doctors

Doctors who dispense for their patients present a particular problem and special arrangements for this service are receiving further study.

### Maternity

Many doctors will continue to give maternity services through the medium of the Obstetric List. Where this is not so, it is envisaged that this service will be provided on an item of service basis and will not be covered by this scheme.

## Joining the Scheme

There would be no ethical objection if doctors invited their patients to join the scheme well ahead of the date of resignation. There will be available drafts of a letter which doctors could if they wished send to their patients. Patients who joined the scheme within a week of the date of resignation would enjoy immediate benefits. It might well be desirable to extend this to all who joined in the first month. But no scheme could survive if it did not stipulate that those who joined after the first month would have to pay for their medical attention on an item of service basis during their first month.

This scheme is put forward to enable those who wish to use a scheme of this type to do so. Many doctors and patients may wish to make their own arrangements as indeed some areas and some individual doctors have already done.

Final details of the B.M.A. Scheme will be published as soon as possible.

### APPENDIX 3.

Additional Allowances for Special Experience and Service to  
General Practice - Report of a Working Party set up by the  
General Medical Services Committee, 1967.



## ADDITIONAL ALLOWANCES FOR SPECIAL EXPERIENCE AND SERVICE TO GENERAL PRACTICE

### Report of a Working Party set up by the General Medical Services Committee

#### INTRODUCTION

1. A Working Party was set up by the General Medical Services Committee on 19th January, 1966, charged with the task of examining the proposals contained in Appendix B (C) (iii) (d) of the Second Report of Joint Discussions between General Practitioner Representatives and the Minister of Health, published on 6th October, 1965, and preparing a scheme for consideration by the profession.

Since then, the Third Report of Joint Discussions on the Family Doctor Service and the Seventh Report of the Review Body have been published and the Special Conference of Local Medical Committees has been held. The Working Party has had these important documents in mind, and has also taken account of the debate on this subject on 8th June, at the Special Conference of Local Medical Committees, and at the Special Representative Meeting held on 21st June, 1966. The following resolutions, *inter alia*, were passed by the Conference:—

"That no scheme of payments for special experience and service to general practice be adopted unless and until the principle of such payments has been discussed and accepted by the Conference and the detailed proposals for implementing such a scheme also be approved by Conference."

"That the General Medical Services Committee be required to consult all general practitioners by plebiscite before accepting any scheme for the distribution of payments for special experience and service to general practice."

#### MEMBERSHIP OF THE WORKING PARTY

D. C. Bowie (Chairman)

D. L. Crombie	W. H. Hylton
Arnold Elliott	E. V. Kuenssberg
A. B. Gilmour	G. Swift
J. P. Horder	G. I. Watson
R. A. Keable-Elliott	(from September, 1966).

For easy reference the whole of Appendix B (C), the relevant part of the Second Report, is reproduced as Appendix I to this report, but the later references in the Third Report and the Review Body's Report mentioned above should be in mind when reading Appendix I.

The paragraphs on the subject of "General Practitioner Differential Payments" from the report of the Royal Commission (February, 1960), also referred to in the Review Body's Report, are

reproduced as Appendix IIa. The relevant paragraphs in the Review Body's Seventh Report are quoted in Appendix IIb. These references form an important historical background to the whole question of Additional Allowances for Special Experience and Service and it is recommended that they be studied before the Working Party's report itself is read.

The Working Party noted that firm proposals for seniority allowances are contained in (C) (iii) (b) of the same Appendix I.

The Working Party accepted at the outset that general practitioners have been opposed to the idea of "Merit" or "Distinction Awards" in general practice, largely based on the question of secrecy and concern as to the method of selection — views repeatedly expressed by the G.M.S. Committee and the Conference of Local Medical Committees.

#### GENERAL CONSIDERATIONS

2. The Working Party is convinced that there should be encouragement and help for the general practitioner who deliberately sets out to improve and augment the Service. It desires at this point to pay tribute to the large number of general practitioners who, without material reward, have in the past and today, prepared themselves specially for their careers, who are keeping themselves up to date with advances in medicine, and who are themselves contributing to advances in knowledge and who are serving their profession otherwise in many ways. After considering methods by which the advancement of general practice can be encouraged and hastened over a wide front, the Working Party concluded that it is possible to define activities of general practitioners which contribute to this end, and which could be fostered by a special allowance.

It believes that if a system of allowances is adopted on the lines it suggests, a major advance will be made towards a new career structure in general practice. Not only will positive inducements be offered to improve standards of practice but general practice will be seen to throw down a challenge to itself devised by its own practitioners. A new system on the lines suggested will also be seen as an important contribution to a new concept of general practice capable of inspiring and attracting a due proportion of specially gifted and ambitious young graduates.

Since the purpose of a special allowance is to promote and recognise contributions to the

advancement of general practice, it will henceforward in this report be referred to as an "Advancement Allowance", but the Working Party states categorically that if its recommendations made in this report are accepted and implemented, Advancement Allowances would not be intended to convey and must not be interpreted as conveying or even implying any judgement as to the professional merit or distinction of recipients in relation to the actual quality of the care which they may give to their patients. The assessment can only be applied to those objective criteria (detailed in paragraph 6) by which a practitioner can be shown to have prepared himself for his vocation and the way in which he now practises this vocation.

The Working Party presents its proposals in a form which it believes will enable general practitioners to reach a considered judgement on them; it has deliberately refrained from including details which it believes should properly be reserved for decision by the authoritative body which would have to administer these proposals in any form in which they might be acceptable to general practitioners. The decisions of such a body would be proper subjects for re-examination at the reviews of the scheme suggested later in this report.

The proposals which follow relate to the United Kingdom as a whole. It may be necessary to vary these outside England and Wales and the Working Party would raise no objection to this provided the principles are retained.

## LEVELS AND NUMBERS OF PAYMENTS

3. The Review Body recommended that payments for special experience and service to general practice should be made as follows (paragraph 215):—

- (i) to 2,500 doctors .. £750 per annum
- (ii) to 100 doctors .. £2,500 per annum

The Working Party considered whether larger numbers of Allowances at lesser rates might be desirable, but concluded that the rates be of such size as would provide real incentives throughout general practice, and therefore bases its proposals on the Review Body figures. In this report the payments will be described as "Advancement Allowance" referring to the £750 per annum payment, and as "Special Advancement Allowance" referring to the £2,500 per annum payment respectively.

## ELIGIBILITY FOR ADVANCEMENT ALLOWANCES

4. The Working Party accepts that to qualify for consideration for an Advancement Allowance a doctor must be receiving a Seniority Allowance ((C) (iii) in Appendix I); in other words, he must have been registered for at least 15 years and have, as a principal, provided unrestricted general medical services under the National Health Service for at least the last 5 years.

In (C) (iii) of Appendix I it was proposed that additional payments for special experience and service to general practice should be paid to doctors over the age of 45 and not normally beyond the age of 65. The Review Body (paragraph 203) was not convinced that these age limits should apply. The Working Party proposes that, as a rule, provided a doctor is receiving a Seniority Allowance, no lower age limit should be prescribed for payment of an Advancement Allowance; this would ensure recognition of the outstanding younger doctor. The Working Party is generally of the opinion that the upper age limit should normally be 65 but an alter-

native suggestion is discussed in paragraph 5 below.

The Working Party proposes further that an Advancement Allowance should be payable for an initial period of 7 years, and that a recipient should be made responsible for re-applying for his Allowance to be continued. The form in which re-application should be made should be determined by the Central Selection Body.

In addition to seniority the Working Party proposes that a doctor's qualification to receive an Advancement Allowance should be determined by the way in which his record shows up when measured against a generally known set of criteria. No doctor would be expected to satisfy all the criteria suggested later, but when these, if adopted, were to be applied, a broad picture of achievement would emerge which would guide a selection body in reaching its decision.

The Working Party considers that no doctor should qualify automatically for an Advancement Allowance merely through tenure of an important appointment or office.

## ELIGIBILITY FOR SPECIAL ADVANCEMENT ALLOWANCE

5. In this report the Working Party has decided not to examine the subject of Special Advancement Allowances in detail, believing that the experience of operating the Advancement Allowances Scheme would be desirable before all the problems could be seen in perspective. The Working Party, however, foresees that applications for Special Advancement Allowances would be subjected to a specially rigorous examination under the criteria proposed below in addition to any further criteria which experience might show to be desirable.

If this view is accepted the Working Party suggests that it may well be three years before conditions applicable to Special Advancement Allowances can be defined and agreed, and it therefore proposes that for the first three years following the introduction of the Advancement Allowance Scheme, the money set aside for the Special Allowances should be used to increase the number of Advancement Allowances, as follows:—

To raise by 300 the total number of Additional Allowances payable to doctors up to the age of 65 from 2,500 to about 2,800 for the first three years, which may be awarded to eligible doctors aged 65 - 70.

When a Scheme for Special Advancement Allowances has been agreed, the 100 recipients thereof could be expected to be drawn from the list of holders of Advancement Allowances and the remaining 200 excess holders of Advancement Allowances would be pruned by the operation of the upper age limit or deaths or retirement.

## CRITERIA

6. The Working Party proposes that the following objective criteria should be applied. Certain of these already attract remuneration, but it is still essential to give weight to these in any attempt to assess special experience and service to general practice. The necessary information should be ascertained through answers to questions on a form prepared for the purpose and completed by doctors who consider themselves to be eligible for an Advancement Allowance. **These criteria are put forward only as a guide and, whilst a "points" system could be devised to measure attainment under each head, the method of working would have to be left to be decided by the Selection Body.** The weighting to be given under some of the items



in the criteria named could be held to be greater than in the case of others, though this is a matter upon which the Central Selection Body would reach its own conclusions. The Working Party, however, considers it proper to call attention to the need for special consideration to certain circumstances, e.g. that of the single-handed practitioner; it is aware of the outstanding services rendered by some doctors in this category, whether urban or rural.

No practitioner would be expected to show proficiency in each and every section.

- (a) **Steps taken by a General Practitioner to prepare himself for General Practice, e.g.**
  - i. Hospital appointments since full registration before entering general practice.
  - ii. Trainee General Practitioner.
  - iii. Additional Vocational Training.
  - iv. Attachments to hospitals; service in the Armed Forces or service or experience overseas.
  - v. Higher degrees and Diplomas.
- (b) **Nature and Extend of Postgraduate Studies, e.g.**
  - i. Formal postgraduate courses and attachments.
  - ii. Informal educational activities, e.g. ward rounds.
  - iii. Membership of medical societies.
  - iv. Special experience, e.g. work as R.M.O., or Ministry of Pensions Tribunals; experience in Industrial Medicine.
- (c) **Development or Use of Certain Organisational Techniques in his own General Practice, e.g.**
  - i. Special premises (purpose built or adapted).
  - ii. Appointment system.
  - iii. Special Record System.
  - iv. Special clinics (well-baby, ante-natal, geriatric, etc.)
  - v. Co-operation with Local Health Authorities. Work in Local Health Authority Clinics. School Medical Service.
  - vi. Obstetrics.
  - vii. Responsibility for G.P. beds in hospital.
  - viii. Use of screening procedures in general practice.
  - ix. Special diagnostic techniques in general practice.
  - x. Part-time sessions in hospital.
- (d) **Contributions to Teaching, e.g.**
  - i. Undergraduate attachment schemes.
  - ii. Lectures to Nurses.
  - iii. Lectures in First Aid.
  - iv. Lectures to Students.
  - v. G.P. Trainer.
- (e) **Contributions to Investigations, e.g.**
  - i. Participation in group investigations.
  - ii. Independent investigations.
  - iii. Publications.
- (f) **Original Ideas in General Practice.**
- (g) **Contributions to the Administration of the Medical Profession, e.g.**
  - i. Membership of Local Medical Committee.
  - ii. Membership of Hospital Boards or Committees.
  - iii. Officer of medical society.
- (h) **Efforts on Behalf of the Community.**
- (i) **Other Relevant Information.**

## REVIEW OF CRITERIA

7. The Working Party advises that the criteria should be reviewed regularly by the General Medical Services Committee, the first review to take place two to three years after acceptance of the scheme.

## SELECTION

8. The Working Party recommends that final selection for Allowances should rest with a Central Selection Body. This Body would be assisted by Regional Panels, who would put forward names for consideration from their own Regions. The exact method of working must be left to be determined by the Central Selection Body, but because of the importance of uniformity in the working of the system, a close pattern of liaison must be maintained between the Central Selection Body and the Regional Panels.

### (a) Central Selection Body.

It is proposed that the Central Selection Body should consist of 11 members (whose standing and reputation will always command the respect of the profession) with, in addition, a Chairman appointed by the Minister of Health after consultation with representatives of general practitioners. It is further proposed that the 11 members should be appointed by the General Medical Services Committee but that not more than four of these should be members of that Committee.

The Working Party considers that one of the members should be chosen because of his experience over a wide field and whilst this member need not possess the general practice qualifications required of other members, he should desirably, but not necessarily, possess a medical qualification. The Working Party further considers that whilst the remaining six members should not represent any particular body, they should be chosen to give expression to the many opinions of those concerned to advance general practice. Ten of the eleven members should be engaged in active general practice, or if retired, should have had ten years experience in general practice and have been principals within the three years preceding their appointment.

One-third of the original members would retire after 5 years; one-third of the original members would retire after 6 years; and one-third of the original members would retire after 7 years.

Thereafter the term of office for members should desirably be five years, though this recommendation should be reviewed in the light of experience. Members should not normally be eligible for re-appointment.

Members will not be eligible for an Advancement Allowance, and the Working Party recommends that they should receive appropriate and comparable remuneration from Exchequer Funds for their services.

A former member of the Central Selection Body should be entitled to apply for an Advancement Allowance after his period of office.

The running costs of the administration of the Scheme should be met from Exchequer Funds.

The Central Selection Body should not be required to give reasons for granting or withholding approval of any application, and the only ground for review of a decision should be on matters of fact.

### (b) Regional Panels.

It is envisaged that every principal eligible for an Advancement Allowance (para. 4) will be sent a questionnaire based on the criteria outlined

in para. 6 above, to be completed and returned in the first instance to the local Regional Panel. The Panel should examine the questionnaire and should be free to make such enquiries from other sources as would help them to assess the applications. Regional Panels should then put forward names for consideration for Advancement Allowances from their own Regions to the Central Selection Body, together with all relevant documents. In the Second Report it was suggested that payments should be made to about 30% of those eligible. The Working Party advises that whilst Regional Panels should bear this percentage in mind, they should not feel inhibited from putting forward names in excess of this figure if, in their judgment a higher percentage seems appropriate in their particular Region. The Central Selection Body would, no doubt, give further guidance on this point.

Regional Panels should be organized on a territorial basis, and the Working Party recommends that there should be nine such panels covering England, Scotland and Wales. Appendix III gives a guide to a possible grouping of L.M.C.s in Regions and these have been chosen to bring about reasonably comparable numbers of general practitioners in Regions, so far as this is attainable, and thereby ensure due consideration being given to all general practitioners. The size of Regions should be reviewed in the light of experience.

Each Panel should consist of seven members who could be eligible themselves for the Advancement Allowance.

Members of the Panel should be appointed by the Central Selection Body after being nominated by the Local Medical Committees in the Region, not necessarily only from their own members. Regional Panels should appoint their own Chairman.

In common with the procedure outlined above for the Central Selection Body, it is proposed that, in the first instance, one-third of the membership of a Regional Panel should retire after 5 years, one-third after 6 years and the remaining one-third

after 7 years. Thereafter the term of office for members should desirably be for five years, though as in the case of the Central Selection Body experience is needed before a final recommendation can be made. Members should not normally be eligible for re-appointment.

Finally, the whole procedure, in common with the criteria, should be reviewed in the light of experience after, say, the first 2 - 3 years, and subsequently at suitable intervals.

### **PARTNERSHIPS**

9. The Working Party has carefully considered the opinion sometimes expressed that, where appropriate, an allowance of this kind should be paid to the partnership rather than to an individual doctor. It is certainly true that the good work of a doctor in a partnership often depends upon the support, and perhaps forbearance, of his colleagues in ways which are sometimes not obvious to others. The terms of reference of the Working Party, however, require it to prepare a scheme for additional allowances to selected doctors for special experience and service to general practice and it has done this. The criteria it proposes are applicable solely to individuals and not to practices. The manner in which payments are used is outside its remit.

### **CONFIDENTIALITY**

10. The Working Party advises that these Allowances should be handled with the same degree of confidentiality as that attached to other payments to doctors from Executive Councils. The Working Party therefore advises that lists of recipients of allowances should not be published. It believes, however, that secrecy should be avoided and advises that lists of recipients of allowances in each Region should be maintained by the Regional Secretariat, that these should be open to inspection by doctors in the Region who themselves qualify for allowances, subject to them undertaking not to publish the information they have gleaned.

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## **APPENDIX I**

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### **Second Report of Joint Discussions between General Practitioner Representatives and the Minister of Health — Appendix B(C) (i), (ii), (iii)**

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#### **(C) ADDITION TO THE ALLOWANCE**

##### **(i) Unattractive Areas.**

The basic practice allowance for doctors in areas where there is a long-standing shortage of general practitioners will be increased. This will include all doctors whose main surgery is

situated in the defined area and all the patients on such a doctor's list will be counted in determining eligibility. The appropriate areas will be those which have been "designated" by the Medical Practices Committee for a continuous period of three years up to the date of payment. This criterion will be kept under review.

There is a particular need in these areas for improvement in the conditions under which general practice is carried out. The payment may therefore fall to be reconsidered in the case of doctors who, in the view of the Executive Council (after consultation with the Local Medical Committee), unreasonably refuse an opportunity for such improvement e.g. a move to suitable premises where they can practise as members of a group.

If the Medical Practices Committee reclassify an area in which these payments are being made as other than "designated" the additions will cease after the 12th quarter following the changed classification.

(ii) **Doctors practising in Groups.**

The basic allowance will also be increased for doctors practising with others in a central surgery in such a way that the present definition of the Group Practice Loans Scheme would be satisfied as regards use of premises and working as a group, and provided that they qualify for a basic practice allowance at the full rate.

(iii) **Seniority, Experience and Special Qualifications.**

**VOCATIONAL TRAINING**

- (a) An addition to the basic allowance will be paid to doctors who satisfy certain conditions, not yet settled, about vocational training before entry to practice.

**SENIORITY**

- (b) An addition will also be paid to a doctor whose name has been continuously included in the Medical Register for 15 years and who has been a principal providing unrestricted general medical services under the National Health Service for at least the last five years. Further additions will be paid (i) after ten more years as such a principal, and (ii) after another ten years. Eventually the payments will cease at normal retiring age but for the present, in view of the shortage of doctors, they will be continued until age 70. These payments will absorb payments under (a) above.

- (c) For the first three years of the new system of payments, the additions at (b) will be subject to no further conditions. After that the doctor must show that during the years from 1966 until the year in which he becomes eligible (or since entering general practice if the period is shorter) he has attended a prescribed average number of sessions per annum of approved postgraduate training. Any addition made under this heading will be withdrawn three years after the annual average of sessions falls below the prescribed number.

**SPECIAL EXPERIENCE AND SERVICE TO GENERAL PRACTICE**

- (d) The Government attach great importance to financial recognition of special experience and service to general practice. The Review Body have indicated their readiness to recommend additional money for this purpose, and have recommended that the profession and the Departments should try to devise an acceptable scheme. The profession's representatives made it clear that no such proposal appeared in the Charter and that they had no mandate to agree. Nevertheless, the Government think that the case for such a development is so strong that the modified capitation scheme should contain provision for it. Indeed, they would regard it as a necessary complement to payments for seniority, which the profession have favoured in the past. They accordingly propose that further additions for special experience and service to general practice will be paid to selected doctors, over the age of 45 and in receipt of a payment under (b). Selection will be in a manner and on the basis of criteria to be agreed between the profession and the Health Ministers. Additions of this kind will not normally be paid to a doctor beyond the age of 65. It is contemplated that payments should be made to about 30% of those eligible. There will be two levels of payment and the Review Body will be asked to determine a fixed number of payments at each level. The payments will include a very limited number at the higher level, which will be substantially above the lower.

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**APPENDIX IIa**

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**"General Practitioner Differential Payments"—paragraphs  
345 - 351 of the Royal Commission's Report (February, 1960)**

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345. The recommendations which we have so far made will have the effect of raising the remuneration of general practitioners all round. They are unlikely in themselves to make any significant alteration to the pattern of spread. Other developments which might accompany or follow the implementation of our proposals could further reduce the already small spread of incomes; list size

is at present the main determinant of income and if the maximum permitted list were again to be reduced, a number of the higher incomes would be reduced with it. Proposals to increase the remuneration of semi-specialist general practitioner obstetricians may well have the effect of raising some incomes at about the middle level and thus, from another direction, increasing uniformity. We are of



course aware that the nature of general medical practice is less favourable to extremes of income than that of most other professions or the other branch of the medical profession. Nevertheless we think it undesirable that the pattern of earnings should be reduced (or indeed raised) to such a uniform level as would be indistinguishable from a salary, and we feel that, difficult though the task may be, it is important that an effort be made to devise a system, acceptable to the profession, whereby some general practitioners may earn a good deal more than the average.

346. We do not believe that constant striving for increased income is or should be the main incentive to good general practice, but at the same time we think it must be discouraging both to existing doctors and to potential recruits if a really first-rate practitioner has so little prospect of earning more than one who is merely satisfactory. We believe that before the war a talented and ambitious young general practitioner could reasonably look forward to an income well above the average, and we think this was on balance a good thing for medicine. A few higher earners in any profession are apt to make an impression out of all proportion to their numbers and rightly or wrongly to raise the esteem in which many hold their profession. We think it desirable that general medical practice should, even if only to a limited extent share this advantage with other professions.

347. We are aware that many general practitioners have expressed strong views against any sort of "general practitioner merit award system". Their views may be partly founded on a misunderstanding of the nature of the existing distinction award system for consultants, and we trust that our chapter on consultants may remove some of this misunderstanding. Unless one believes, as a matter of principle, in equal incomes for all, one must surely wish to see the higher incomes associated with some desirable quality, and among professional men the obvious quality is professional distinction. In professions which practise privately for fees there is a general tendency, subject to exceptions no doubt but generally operative for the better practitioners, to secure the larger incomes. Similarly among salaried people, professional or otherwise, there is a general tendency for the abler people to secure larger salaries by promotion. There has probably never been an organisation in which some of the promotions have not been criticised, and those who are responsible for making decisions on promotion of staff know it to be a difficult task in which mistakes must inevitably sometimes be made. Nevertheless the decisions have to be, and are, made and on the whole the system works well. It appears to us that many of the objections to differential rates of remuneration for general practitioners rest on a cynical belief that selection for the higher rates could never be honestly or competently done. We find it hard to believe that in medicine alone there is a complete lack of that selective ability which is exercised in practically all other occupations. Fears have been expressed that the existence of a system of selection would lead to an undesirable atmosphere of currying favour, but we do not accept that such an atmosphere is the prevailing one among those people who serve in the

armed forces, industrial and commercial organisations, universities or the civil service, where careers are pursued by way of selection for promotion.

348. Nevertheless, in view of the feeling that exists and the doubts expressed to us by the British Medical Association, we do not think it appropriate that we should ourselves produce a detailed scheme. General acceptance is essential, and this means, in the circumstances, that the profession must work out a scheme for themselves. We therefore limit ourselves to recommending the overall finance. We accordingly recommend that, over and above the finance needed to meet our other recommendations, a special fund of £500,000 per annum be provided expressly to recognise distinguished general practice by additional remuneration. We recommend that this sum be applied in accordance with a scheme to be agreed between the profession and the Government, and that until a scheme is agreed, the money should revert permanently to the Exchequer. Thereafter any part of the fund which is not expended in any year should similarly revert.

349. While leaving the details of such a scheme to be worked out by the profession and the Government, our recommendation is made on the assumption that it will include, among other characteristics, the following:—

- (a) The additional remuneration of a selected general practitioner should be not less than £500 per annum and might well amount to £1,000 or even more.
- (b) Those selected for the additional remuneration should normally continue to enjoy it until retirement.
- (c) The addition should be treated in all respects as part of the practitioner's National Health Service remuneration.

We would add that perfection is not to be hoped for, and in particular the following imperfections must be expected and tolerated:

- (i) While the criteria and methods of selection should enjoy wide support they cannot hope for universal approval.
- (ii) It must not be expected that the selectors will be infallible, and there are bound to be individual cases of unrecognised merit, as indeed there have always been among self-employed professional men.

350. We have spoken above of "selectors", and it is in our minds that a possible scheme might make use of the judgment of a number of respected persons. We do not, however exclude the possibility of a scheme in which an agreed system of objective factors might lead automatically to the selection of certain doctors. A further possibility would be a combination of both systems, where objective factors would be used as a preliminary qualification, reducing the field from which final selections would be made by personal judgment.

351. We hope that when such a scheme is under consideration advantage will be taken of the advice of the College of General Practitioners upon the criteria which might properly be used.

## Seventh Report of the Review Body on Doctors' and Dentists' Remuneration — paragraphs 201 - 203

201. The representatives of the general practitioners made it clear that they had no mandate to agree to payments for special experience and service to practice. They were, however, able to suggest levels at which these payments might be set if they were included in the new system of remuneration. The Health Departments think that the case for these payments is so strong that the new system should contain provision for them; indeed, they have made clear their view that they regard these payments as a necessary complement to payments for seniority. We share the Health Departments' view of their value, and in commending them to the profession we wish to emphasise again that they really are additional payments: if they were not included in the system, we should recommend that the money which would have been used for them should not be available, rather than that it should be distributed in other ways.

202. The Second Report of Joint Discussions proposed that these payments should be made to selected doctors over the age of 45 and in receipt of a seniority payment, and should not normally be payable beyond the age of 65. It was suggested that about 30 per cent of those within the field should be selected to receive the payments, and that there should be two levels of payment, the higher of which would go to a very limited number of doctors. The Health Departments and the profession's representatives both suggested that there

should be 3,000 payments at the lower level and 100 at the higher. The profession's representatives proposed that the payments should be the same as the C and B distinction awards for consultants; the Health Departments suggested that the lower payment might be about £500 and the higher about £1,500.

203. We are not convinced that the field of selection for these payments should be limited to doctors aged between 45 and 65. Though distinction in general practice no doubt comes partly from experience, the sort of distinction which these payments will recognise could in some cases emerge well before a doctor reached the age of 45. We do not make a formal recommendation on this, which is something to be settled between the Health Departments and the profession's representatives; but it would in our view be preferable that eligibility for these payments should not be formally limited by age. Furthermore, we think that it would be a mistake to link these payments at all closely, either in terms of number or value, to distinction awards for consultants; that might be taken to imply that these payments will be more like distinction awards for consultants than we think they will in practice prove to be. For these reasons we are recommending different numbers and values for the payments than those which have been suggested to us; but the payments we recommend will, we hope and believe, constitute an appreciable recognition of distinction in general practice.

## APPENDIX III

### REGIONAL PANELS

#### Grouping of Local Medical Committees into Regions

A plan has been prepared dividing the country into nine Regions: seven for England and one each for Wales and Scotland. When drawing up this plan regard was paid to the ideal of devising regions that would contain as near as possible the same number of eligible principals. In achieving this, use has been made of the system and figures employed

by the G.M.S. Committee for election purposes as far as England is concerned, but it seemed prudent to have one region respectively for Wales and Scotland.

A map is appended indicating the Regions by numbers.



#### APPENDIX 4.

Material distributed at a Press Conference for reporters from the local newspapers held by the Hertfordshire Local Medical Committee during the national newspaper strike of June 1970.



# HERTFORDSHIRE LOCAL MEDICAL COMMITTEE

Secretary: H. W. FITTON

Telephone:  
KNEBWORTH 2254

21 ST. MARTINS ROAD,  
KNEBWORTH, HERTS.

9th June, 1970

## GOVERNMENT ACTION ON REVIEW BODY REPORT

An OPEN MEETING of General Medical Practitioners in Hertfordshire, working in the National Health Service, was called by the Local Medical Committee on the 8th June, 1970, to discuss what steps should be taken in view of the Government's treatment of the Twelfth Report of the Review Body, published on the 5th June. A total of 170 Doctors, representing practically every practice in the County, attended this meeting, including 13 Hospital Doctors.

The meeting recommended that the medical profession should be advised without delay:-

- (a) that all co-operation with the Government in the administration of the N.H.S. should cease forthwith at all levels;
- (b) that all doctors both in general practice and hospitals, should cease to give all certificates in any form of incapacity for work; leaving it to the Government to make its own arrangements for dealing with the public's claims under National Insurance.
- (c) The meeting also recommended that it be made clear to the Government that continued participation in the N.H.S. of the medical profession must be dependent upon the continued existence, and acceptance by the Government, of the independent Review Body, in the terms laid down by the Royal Commission on Doctors' and Dentists' Remuneration, or as amended by agreement between the Government and the profession.
- (d) Immediate consideration should be given to the further steps that should be taken if the Government continues to refuse to implement in full the recommendations contained in the Review Body's Twelfth Report.

(Signed) J.H.MARKS

Chairman.

## APPENDIX 1

Ten years ago the Government and the doctors in the National Health Service agreed that an independent Review Body should advise about doctors' pay. This advice was to be published promptly - and, save in quite exceptional circumstances, was to be accepted by both parties. The latest advice of the Review Body was first held up for two months, and then the Government said it would not put it all into effect.

This is a breach of an agreement, which by destroying confidence amongst doctors in the N.H.S. must damage the Service. Already several hundred of our doctors, whom we need badly here, are going abroad every year, because of dissatisfaction with the N.H.S.

To show how seriously doctors regard this broken agreement - and to obtain justice - all doctors have been advised not to issue certificates of unfitness for work. All the doctors' other work will go on as before, and all other kinds of certificates will be issued.

No patient will, therefore, suffer by this action, nor will the non-issue of certificates result in more than, at worst, slight inconvenience and delay in receipt of benefits. It is the Government's responsibility to pay out sickness and injury benefit, and this can be done without medical certificates.

If you believe you are unfit for work because of illness (or injury) and that you are entitled to National Insurance benefit, you should inform the local office of the Department of Health and Social Security as soon as possible - either by calling there, or by writing.

Give your full name and address and your national insurance number (if known), the name and address of your employer and your occupation. Also state your date of birth, and list any dependants, e.g. wife or children if you claim extra benefit for them. Reply promptly to any request for further information from the Social Security Office.

## APPENDIX II

### DESIGNATED AREAS

These are the areas which are considered so under-doctored by the Medical Practices Committee, a Government Agency, that the Government actively endeavours to persuade Doctors to practice in them.

For an area to qualify as "Designated" there must be at least

2500 Patients per Doctor

In the following List of Designated areas, those marked with an asterisk have been Designated for at least three years:-

	<u>PATIENTS PER DR.</u>
Berkhamsted U.D. and R.D. (excluding Tring Rural Area)	2951
* Elstree and Boreham Wood	2848
* Hatfield R.D.	2835
* Hemel Hempstead M.B. (excluding Grove Hill)	2935
Hitchin U.D.	2810
* Oxhey	3076
* Potters Bar U.D.	2864
Rickmansworth and Chorleywood	2684
St. Albans City (with St. Stephens and London Colney)	2669
* Stevenage U.D. (excluding St. Nicholas)	3240
Ware U.D. and R.D.	3120
* Welwyn Garden City U.D.	3045

APPENDIX 5.

How are N.H.S. Family Doctors to be Represented?  
A Report by the General Medical Services Committee.  
Document S.C.12 (1972-73).

**British Medical Association**

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**A REPORT OF THE GENERAL  
MEDICAL SERVICES COMMITTEE**

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**HOW ARE N.H.S. FAMILY DOCTORS  
TO BE REPRESENTED?**

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**PLEASE READ THIS REPORT, AND KEEP IT AFTERWARDS.**

**IT IS ABOUT A MATTER OF GREAT IMPORTANCE TO  
GENERAL PRACTICE: NAMELY, THE PROPOSALS, IMPLIED IN  
RECENT DECISIONS OF THE BRITISH MEDICAL ASSOCIATION,  
TO ABOLISH THE PRESENT ARRANGEMENTS  
FOR LOOKING AFTER YOUR INTERESTS AS A FAMILY DOCTOR  
IN THE NATIONAL HEALTH SERVICE.**

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## INTRODUCTION

1. In May this year the *British Medical Journal* published Sir Paul Chambers' Report on the B.M.A. constitution. In November the Report was considered by a Special Conference of Representatives of Local Medical Committees and, a week later, by a Special Representative Meeting of the B.M.A.

Both meetings reached a decision on the Chambers Report by large majorities. Their decisions were completely opposed to one another.

This has made it necessary for the B.M.A. Council to make a further report to the Representative Body, for which reason the Council has asked for the advice of its Committees, including the General Medical Services Committee. If we are to give the best advice we can, we, the G.M.S. Committee, believe we should sound the opinion of our constituents — N.H.S. practitioners as a body.

The events leading to today's situation can be summarized quite briefly, although their significance, which we will deal with later, is far-reaching.

2. Among other things Sir Paul Chambers recommended:

- (a) that in all B.M.A. affairs, including the handling of N.H.S. doctors' interests, only B.M.A. members should play any part, whether as voters or committee members, and
- (b) that the autonomous committees and their "craft" conferences should be abolished.

3. There are two so-called autonomous committees of the B.M.A., the General Medical Services Committee and the Central Committee for Hospital Medical Services. Their "autonomy" as standing committees of the Association is conferred by an annual resolution of the B.M.A.'s Representative Body. For many years this has been passed in the following terms:

That the autonomous powers of the General Medical Services Committee and the Central Committee for Hospital Medical Services be renewed in respect of the year 19—/—, on the understanding that no action be taken by either of these committees which may prejudice the interests of another part of the profession without full prior consultation with the interests concerned and that their autonomous powers be used so as to expedite the work of the Association.

In other words the autonomy conferred is limited to the fields of interest of the two committees. Also it is subject to an overriding proviso concerning the work of the B.M.A. as a whole, and in many instances the work is necessarily carried out in conjunction with other B.M.A. Committees and the Council of the Association.

4. Chambers' recommendations, referred to above, cut right across the long-established system (see paras 8-12)

by which a B.M.A. Committee has been able to speak for all family doctors in the Health Service, and has been recognized by successive governments as representing them. All these doctors, whether they are B.M.A. members or not, have a vote in electing local medical committees, and all local medical committees are responsible, directly or indirectly, for electing two-thirds of the members of the G.M.S.C.

5. If the B.M.A. puts Chambers' proposals into effect, four new standing committees, two for general practice and two for the hospital service, would be elected entirely by the Annual Representative Meeting. In turn, the A.R.M. would be elected partly by the Divisions and partly by the (new) Area Councils of the B.M.A. In both, only B.M.A. members, some two-thirds of the profession, would have any say, and the members of the new general practice standing committees would owe their election ultimately to the votes of B.M.A. members whether general practitioners or not.

6. To complete this introduction where it began, on the 8th November the Special Conference of Local Medical Committees resolved with only a very few dissentient votes:

"That this Conference reiterates its policy that there must be no alteration in the principle of L.M.C./Conference/G.M.S.C. structure".

Seven days later the Special Representative Meeting resolved by 217 to 92 (a 70% majority):—

"That this Meeting accepts the Chambers Report in principle".

The S.R.M. took this decision, as it had every right to do, against the advice of the B.M.A. Council.

And also by a large majority the S.R.M. resolved:—

"That the Council be instructed to prepare a further report and the necessary changes in the articles and by-laws in the light of the decision of the Representative Body that the Chambers report should be accepted in principle and to report to the R.B. in due course".

7. With only a few months left before it must make its report to the 1973 A.R.M., the Council has now asked the G.M.S. Committee for its observations on this unprecedented and difficult situation. With a recent, overwhelming mandate from the Conference of L.M.C.'s, we, the G.M.S. Committee, are convinced that our advice to the B.M.A. Council must be firmly based. Hence, we are again reporting to all N.H.S. general practitioners, and calling another special Conference. We shall recommend to that Conference that the issue involved is so crucial that every N.H.S. family doctor must have the chance to indicate his or her wishes, by means of a postal referendum.

## HOW FAMILY DOCTORS ARE REPRESENTED

### THE PAST

8. It may be helpful to refer briefly to the history of the present arrangement for representing N.H.S. general practitioners. After Lloyd George's National Insurance Bill had been enacted, local medical committees received statutory recognition in 1912. They were then set up with the help of the Divisions and Branches of the B.M.A. At the same time the B.M.A. Council appointed an interim central committee to deal with National Insurance general practice. A year later the Representative Body of the B.M.A. approved a model constitution and rules for local medical committees. The interim committee appointed by the B.M.A. Council was succeeded by an Insurance Acts Committee (the direct predecessor of the General Medical Services Committee) and, again, this was set up by the B.M.A. In 1914 there took place the first Conference of Local Medical

and Panel Committees. This Conference discussed a proposal to establish a separate, permanent, central organisation to represent these committees. This proposal was turned down. Instead, it was resolved that the B.M.A. should set up a permanent committee for this purpose, and that the Conference should nominate six of the Committee's members.

9. At the end of the first World War the Representative Body of the B.M.A. agreed that 18 members of the B.M.A.'s Insurance Acts Committee should be directly elected by grouped Local Medical and Panel Committees. At that time the B.M.A. withdrew the requirement that all members of the I.A.C. must be members of the Association. Three years later, in 1921, the Representative Body agreed that the Chairman of the L.M.C. Conference should be an ex officio member of the Insurance Acts Committee.



10. From that time, 50 years ago, things have gone on without any major change in principle, although electoral arrangements and the number of members have varied. Indeed, in 1971 the Representative Body resolved that it was of the opinion that any reorganisation of the Association which did not take into consideration the position of local medical committees and provide some means of co-ordinating their work with that of the Association could not be effective. This resolution moreover was a simple repetition of one passed more than 50 years earlier. Since that first decision (endorsed in 1971) there have been a number of crises in N.I. and N.H.S. practice, and in all these the B.M.A. and the G.M.S.C. have acted with complete unanimity.

## THE PRESENT

11. We have set out in the Appendix to this Report the present composition of the G.M.S. Committee and a very brief account of how it does its work. On foundations laid 60 years ago, we have now reached the position whereby, each year, 164 local medical committees elect some 260 representatives to the Conference. These 164 committees, grouped into constituencies, elect 38 members directly to the G.M.S.C. The Conference itself elects a further six members of the G.M.S.C., and in electing its Chairman adds a further ex officio member. So, out of a total membership of 66, the G.M.S.C., though a B.M.A. committee, contains a large majority (45) of members elected directly or indirectly by the local medical committees. In turn, the local medical committees are elected by all principals in N.H.S. general practice.

12. The terms of reference of the G.M.S. Committee (see Appendix) embrace all matters to do with family doctors' day to day work. The terms and conditions of service (contained in a statutory instrument) form one of the most important of these. Also, we deal with questions of doctor's pay. So far as the amount is concerned, we have done this by regular submissions to the Medical and Dental Review Body, and so far as conditions are concerned (as set out in the Statement of Fees and Allowances), directly with the Health Departments. The G.M.S.C. is also consulted by the Medical Practices Committee, to which it nominates members, and it deals direct with the Government on all matters that affect general practice in the N.H.S. To do these things, the G.M.S.C. has annually been given autonomy in the terms of the resolution quoted in paragraph 3. Subject to these conditions, the Committee is finally responsible for decisions which affect the working lives of all of the 23,000 family doctors in the Health Service.

## THE FUTURE?

13. If the Representative Body revises the B.M.A. constitution in accordance with its decisions on the Chambers Report, the arrangements we have just described will be wiped out. Conditional autonomy, and the waiving of the need for all participants to be members of the B.M.A. will no longer exist. In place of the L.M.C./Conference/

G.M.S.C. organisation, the Chambers Report suggests a procedure which we can summarise as follows. Local members of the B.M.A., in Divisions, will elect representatives to the Representative Body, as they do now, under certain rules which aim at proportional representation and a balance of age groups. An equal number of members of the Representative Body will be elected by the new Area Councils of the B.M.A. (which will have been elected, in turn, by B.M.A. members only, on a "craft" basis). The Representative Body elected in these two different ways will in turn elect all members of B.M.A. central committees. This includes the two committees which Chambers proposes should replace the G.M.S.C. — one to deal with terms and conditions of service and the other with advice to the Government on the N.H.S. Chambers also proposes that all those who serve the B.M.A. in an elected capacity should have their tenure of office subject to a fixed limit (6 - 9 years). They would be eligible for re-election after a break of one year, or one term, as the case may be.

14. If these Chambers arrangements are substituted, then local medical committees, which are the elected local representatives of all N.H.S. family doctors, will have no B.M.A. channel and, indeed, no right to take part in electing the B.M.A.'s general practice committees. Furthermore, on those committees, the cultivation of expert knowledge by continuous service and experience will be impossible. Thirdly, committees elected in the new way (remembering that about two out of three doctors are B.M.A. members) could not claim to speak for all doctors in any branch of practice. This could mean that no longer would one single body be recognized by the Government as representing all doctors in N.H.S. general practice.

15. There may be a reasonable case for the single, unified electoral structure (Division-Area Council-R.B.-Central Committees), which Chambers has proposed, to deal with Association affairs. The G.M.S.C. believes it is demonstrably the case that regulation of the working conditions of N.H.S. general practitioners can never be exclusively a B.M.A. affair and must continue to be in the hands of their own elected representatives. The only criterion in choosing these representatives must be their ability and effectiveness in serving the interests of those who elect them. The present "federal" constitution of the B.M.A., together with the annual resolution giving conditional autonomy, provides just such an arrangement.

16. To sum up, the new N.H.S. legislation provides for the continuance of L.M.C.'s in England, Wales and Northern Ireland, with equivalent arrangements in Scotland. It is unthinkable that these committees will no longer wish to consult together in Conference. Moreover, such a Conference of Local Medical Committees, if it is to be effective will require to elect — or otherwise recognise — an executive body. Should the Association adhere to its decision not to provide for this executive body within its own structure, then the vacuum will be filled, either by some already existing organisation, or by the creation of an entirely new one (see para 18).

## THE QUESTION BEFORE US

17. The basic question which now faces family doctors in the Health Service can be put simply:

Do they want to be represented by (1) a committee elected, in effect, by all general practitioners or (2) by general practitioners elected through an organisation of doctors in all branches of medicine, and limited to members of that organisation alone?

18. If a majority of doctors answer Yes to the first of these alternatives, and if the B.M.A. keeps to its decision in principle taken at the S.R.M. in November 1972, local medical committees will have to set up, through their Conference, a new organisation for N.H.S. general practitioners outside the British Medical Association. Furthermore, to secure the

protection of the Industrial Relations Act†, whatever organisation is set up must meet the requirements of that Act. That is, it would have to be registrable under the Act, and so enjoy protection in the event of action being taken to further an industrial dispute. Another result would be that every N.H.S. family doctor would be asked to support such an organisation, and would be expected to contribute

† Under the provisions of the Industrial Relations Act 1971 as they now stand protection under civil and criminal law is conferred only upon registered organisations (either of workers or of employers). It is clear from S.84 (2) that no organisation formed after the passing of the Act can (like the B.M.A.) be admitted to the Special Register. Any such new organisation would have therefore to seek admission to the ordinary Register, i.e. seek to become a "trade union" within the meaning of the Act (S.61 (3)).



to its cost. This would be nothing new, for nearly all family doctors have for many years been paying money to the G.M.S. Defence Trusts. The funds already accumulated in the Defence Trusts, by the voluntary levies of several generations of family doctors, could be made available to whatever new organisation the Conference were forced to set up.

19. On the other hand, if most general practitioners favoured the second alternative (representation through the

B.M.A.) then local medical committees would have to accept that they would cease to play a part in electing the central committee and have no direct influence on central policy. Under the Chambers proposals the one body which would have the absolute last word in all matters of policy would be the Representative Body of the British Medical Association, electing all committees and a central executive. Non-members of the Association would have neither voice nor vote in any part of this procedure.

## WHAT WE BELIEVE

20. Before they reach a decision on this fundamental question, there is one more consideration for all family doctors. It is well known that the general practitioner in the N.H.S. does his work under contract for service. This is to say, he is a contractor. All doctors in other branches of the N.H.S. work under a contract of service (full or part-time). They are salaried employees. For general practitioners, this contractor status is essential to their freedom to practise where, when and how they wish (subject only to what the terms of service require); freedom to look after their patients as they see fit; and in the last resort, freedom to withdraw from the contract without ceasing to care for patients. In the G.M.S. Committee's view, it cannot be said too often or too emphatically that this freedom of action is vital if medicine in this country is to remain a liberal profession. Moreover, it guarantees free choice of doctor by the Service's users — the patients. In an entirely salaried service, this they would not have.

21. History has shown occasions when only this contractor status has enabled family doctors to take effective industrial action. Sometimes this was as much in the interests of doctors in other branches of medicine as in the general practitioners'. The experience of 60 years teaches that family doctors in a National Health Service need a representative organisation which culminates centrally in a body with ultimate control of policy, and directly answerable to family doctors through a comprehensive, democratic process.

22. Because of these considerations, family doctors are in a different category from doctors in other branches of the Service. This will remain so unless they too choose to become salaried employees. Their preference for contractor

status has been recognised in the latest legislative provisions for continuing the National Health Service after 1974. These provisions allow for local medical committees to continue, and for statutory family practitioner committees, which will succeed Executive Councils in England and Wales. Different arrangements will exist in Scotland and Northern Ireland, but in each country the local medical committee (or equivalent) will continue under statute to carry out advisory and other functions in each N.H.S. Area, including the provision of the medical members at medical service committee hearings. In England and Wales moreover the local medical committee will directly nominate eight members to the family practitioner committee, as at present it does to the Executive Council.

23. Experience has also shown that this difference of status and the difference of administration need not prevent family doctors from working together with other branches of the Service. But the differences do absolutely prevent "unity of the profession" being interpreted in this context to mean that all doctors working in the Health Service are in exactly the same position. Once doctors realise this, then in many matters the profession can speak with one voice. But in matters that concern themselves alone, no group of doctors who comprise a distinct branch of the National Health Service, can possibly have a majority decision imposed upon them. In other words, the G.M.S.C. still maintains that a unitary structure, as proposed by the Chambers Report, is not appropriate to the representation of doctors in the N.H.S. On the other hand, a federal structure, which could be a modification of today's arrangements on the lines proposed by the B.M.A. Council\*, could well bring about the greatest possible agreement and co-operation within the profession and would have the full support of the G.M.S. Committee.

## WHAT WE RECOMMEND

24. The G.M.S. Committee has been asked to formulate advice to the B.M.A. Council in a situation where there is a clear conflict of opinion. This conflict cannot be disguised. On one hand, nearly 100% of the elected representatives of those who, in turn, represent 100% of family doctors have reaffirmed their view on the nature of the organisation which is to serve them. On the other hand, a 70% majority of those elected to represent the two-thirds of the profession which belongs to the British Medical Association takes an absolutely opposite view.

25. The G.M.S. Committee believes it must place the issue before all local medical committees and ask them through their elected representatives, to answer certain questions: First, should the present system of representation of N.H.S. general practitioners continue to consist of an L.M.C./Conference/G.M.S.C. structure? Next, and of great importance, the Conference will be asked to consider and,

if it wishes, confirm the view it has expressed recently and more than once: that its overwhelming preference is to continue to work, if possible, within the B.M.A. structure? Third, if the Conference reaffirms its policy, and if it proves impossible for the representative machinery to remain part of the British Medical Association, the Conference will be asked to decide whether to set up an independent organisation of family doctors directly answerable to local medical committees and, through them, to all N.H.S. practitioners? Finally, should Conference adopt decisions of this nature, does it endorse also our view that all N.H.S. family doctors should be requested to record their views on these fundamental issues?

\* See Interim and Supplementary Reports of Council, (Supplement, B.M.J. 22nd July and 16th September, 1972 and Appendices I and II, G.M.S.C. Report S.C.2, 1972-73).

## THESE ARE OUR RECOMMENDATIONS:

- (1) That it be reaffirmed that the system of representation of National Health Service general practitioners should continue in principle to consist of an L.M.C./Conference/G.M.S.C. structure.
- (2) That this Conference requests the General Medical Services Committee to repeat the invitation of 60 years ago to the British Medical Association to provide for the structure to remain within its constitution.
- (3) That this Conference considers that in the event of such invitation being refused, steps be taken to establish an independent organisation representative of all N.H.S. general practitioners.
- (4) That following this Conference all N.H.S. general practitioners be invited by postal referendum to record their views.

PLEASE READ AND PRESERVE THIS REPORT IN CASE A POSTAL  
REFERENDUM TAKES PLACE

## APPENDIX

### GENERAL MEDICAL SERVICES COMMITTEE

The General Medical Services Committee is a standing committee of the B.M.A. with the following terms of reference:—

"To deal with all matters affecting practitioners providing general medical services under the National Health Service Acts and any Act amending or consolidating the same and to watch the interests of those practitioners in relation to those Acts."

It has for many years carried out its task under the terms of an annual resolution of the Annual Representative Meeting quoted earlier:—

"That the autonomous powers of the General Medical Services Committee and the Central Committee for Hospital Medical Services be renewed in respect of the year 19—/—, on the understanding that no action be taken by either of these committees which may prejudice the interests of another part of the profession without full prior consultation with the interests concerned and that their autonomous powers be used so as to expedite the work of the Association."

The membership is made up of:—

- 38 elected by all the Local Medical Committees of the U.K. (grouped for the purpose)
  - 6 elected by the Conference of Representatives of L.M.Cs
  - 2 elected by the Young Practitioners Subcommittee of the G.M.S. Committee
  - 2 nominated by the M.P.U. section of the Association of Scientific, Technical and Managerial Staffs
  - 1 nominated by the Medical Women's Federation
  - 6 elected by the Annual Representative Meeting of the B.M.A. (4 England and Wales; 1 Scotland; 1 Northern Ireland)
  - 5 nominated by other B.M.A. Committees (2 Central Committee for Hospital Medical Services; 1 Public Health Committee; 1 Private Practice Committee; 1 Ophthalmic Group Committee)
- together with 6 ex officio members:—
- the four Chief Officers of the B.M.A.
  - the Chairman of the Conference of Local Medical Committees
  - the Chairman of the Scottish General Medical Services Committee

The G.M.S.C. can co-opt 2 further members active in the field of vocational training, and 2 further members to represent experience not otherwise represented.

The Committee usually meets every month except August. To carry out its remit to deal with all matters affecting N.H.S. general practitioners the G.M.S.C. appoints:—

- a Negotiating Team of 5 members which meets government officials of the Health Departments every month and which is primarily responsible for all Review Body business and evidence;
- the Scottish G.M.S.C. and the G.M.S.C. (Wales);
- specialist subcommittees and groups to deal with

- Hospital matters
- Maternity Services
- Rural Practice and Dispensing
- Practice Premises
- Statutes and Regulations (Terms of Service)
- Vocational Training and Education
- Young Practitioners' affairs
- Liaison with the Royal College of General Practitioners
- Superannuation
- Rent and Rates Payments.

The G.M.S.C. is recognised by government as representing all N.H.S. general practitioners and is responsible also for representing their interests outside its own immediate sphere of activities. It does so by nominating members to many other B.M.A. Committees and to a number of other bodies outside, amongst which are

- the Medical Practices Committee
- the General Practice Finance Corporation
- the Council for Postgraduate Education and Training
- the Poisons Board
- the British National Formulary Editorial Committee
- Prescribers' Journal Management Committee
- the Central Manpower Committee (Hospital Medical Staffing)
- the Joint Pricing Committees
- Medical Advisory Committees (under the N.H.S. Service Committees and Tribunal Regulations).

These are but a few of the broad spectrum of N.H.S. general practitioner interests in which G.M.S.C. members are engaged.

Although the G.M.S.C. is a Standing Committee of the B.M.A. about 80% of the cost of the many activities outlined are not a charge on B.M.A. funds. They are paid for very largely by the General Medical Services Defence Trust, to which all L.M.Cs contribute, and from the N.I.D.T. fund which was built up in the years 1919 - 1948. Local Medical Committees are able to make these contributions because the large majority of all N.H.S. general practitioners have for almost 60 years supported the voluntary levy. A full statement of account is made each year to all G.Ps in the Annual Report of the G.M.S.C. Annual income from Local Medical Committees to the G.M.S.D.T. is about £128,000. Total gross income, including investment income, is about £188,000 per annum which after deduction of tax leaves approximately £155,000 available to meet expenses and transfers to reserves. Total outgoings at present are in the region of £100,000. Out of this sum is paid:—

- the cost of the Annual and Special Conference of Representatives of L.M.Cs.
- the cost of G.M.S.C. meetings, of its subcommittees and groups.
- the expenses of G.M.S.C. members serving on other bodies (unless paid by government).
- the honoraria claimed by members to meet the cost of locums, etc.
- the cost of preparing, presenting and publishing evidence to the Review Body.
- the cost of publishing and sending to all N.H.S. G.Ps the Annual Report of the G.M.S.C.
- the fees of legal, economic, statistical and other advisers.

The B.M.A. provides the G.M.S.C. (and its Scottish, Welsh and Northern Ireland counterparts) with a medical secretary's services, provides accommodation for all meetings held on its premises, and access to all its service departments, e.g. records and filing, typing and duplicating, finance and accounting, the total cost of which is estimated to be £25,000 per annum.

From this necessarily condensed account can be appreciated something of the wide range of the work done by the G.M.S.C. on behalf of all N.H.S. general practitioners, and its long-established symbiotic relationship with the British Medical Association, the continuance or discontinuance of which is the question which now faces N.H.S. general practitioners, the local medical committees which they elect, and of course the B.M.A. itself.

APPENDIX 6.

Report of the Working Party on a GMSC Tie.

Document 1212 (1066-67)

## REPORT OF WORKING PARTY ON GMSC TIE

## MEMBERSHIP

The original members were J G Ball and D L Cullick, with B Holden added by co-option later.

## CHAIRMAN

Neither original member would dream of voting for himself, but as neither was prepared either to vote for the other, no Chairman was elected.

## MEETINGS

No regular meetings were held and the business of the Working Party was conducted by means of casual encounters in the North East corner of the Hastings Room and similar places of refreshment, and by means of sporadic correspondence, couched to a varying degree in terms of acrimonious misunderstanding.

## REMIT

The Working Party had been requested to submit a design of a tie for possible use by past and present members of the General Medical Services Committee. The two members of the Working Party held differing views as to the type of emblem which the Committee would favour and as neither was prepared to budge one stitch in his views on this subject, for some time it appeared that no report would be made to the Committee - save possibly a recommendation that in future the GMSC should only appoint working groups with an odd number of members. However, after some time when the prospect of stale-mate was looming large the situation was resolved in a moment of illumination, only to be compared in historic importance with the revelation granted to Archimedes in his bath. The solution so providentially granted was (as is the way with all really fundamental questions) of similar simplicity to that concerning displacement of Attic bath water, namely, to offer the Committee two designs for its consideration. This breakthrough having been achieved, the task of the Working Party was speedily concluded. The two designs for a possible tie now presented can be regarded as to the one being of a formal nature (the 'City' tie), and the other of an informal character (the 'Club' tie).

The GMSC will be able either to choose, or should it be unwilling to exercise its judicial faculty (or, like the Working Party itself, reach a tie) it could accept both. This latter solution would have the twofold advantage of increasing sales and, therefore, the profit available for charity and catering more widely for the haberdashery needs of members, appropriate to a greater variety of social occasions.

## CO-OPTION

The rapid progress referred to above, resulting in the present display of designs and of comparable neckwear was only achieved following the co-option of the Working Party of B Holden as "member for supply". Dr Holden by virtue of his ties with the

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silk industry - for of him it can truly be said "Lacclesfield is his washpot and over Cheshire has he cast out his shoe" - made a quite invaluable contribution to the practicalities of the exercise.

#### THE DESIGNS

The Working Party believes that the Committee would wish to have some brief notes on the two designs now available to it.

(a) The City Tie: The design, based on features of the Arms of Sir Henry Brackenbury, incorporates a red lion rampant surrounded by a wreath of oak twigs bearing golden acorns; the whole being subtitled with the letters "GMSO". These two features of the Brackenbury Arms seem singularly appropriate for the work of the Committee. Students of heraldry will know that the fearsome appearance of the Scottish lion, best seen in its natural habitat at Murrayfield, though occasionally known to exhibit its formidable qualities elsewhere, is associated with a motto which freely translated reads "No one puts anything across me and gets away with it" - a sentiment which can fairly be regarded as quintessentially that of the General Medical Services Committee itself. The oak similarly carries not only Druidical undertones of Welsh lwyel, but also of English phlegmatic defence - heart of oak and all that! Lastly, the golden acorns symbolise that accumulated and hoarded wealth which makes the Committee the formidable champion of general practice which it undoubtedly is.

(b) The Club Tie: This design presents the cock of Aesculapius in a novel form, for in Aesculapius' day cockerels only had one head.<sup>†</sup> The two heads of the bird presently displayed (regardant sinister and dexter) symbolise by the convolution of their respective necks the complexity of the issues with which the Committee is frequently faced - or, alternatively, the complexity which the Committee often will introduce into consideration of a subject of relative simplicity. The bird speaking in two directions simultaneously manifests another of the features of the Committee's activity - a constant desire to obtain the best of both worlds; perhaps the most notable example of which is repeated crowing about the virtues of the unique status of independent contractors, whilst at the same time seeking to obtain from the Health Departments as many as possible of the advantages of the salaried employee. To preserve poise in such circumstances is a rare feat and this is symbolised by the perfect balance shown by the bird perched in the form of a weather vane on its point of vantage. The compass points which bear the initials of the Committee symbolise also the ability to maintain this posture despite all blasts of opinion from whatever point of the compass they may originate. In other words, the GMSO stands four-square and firm despite the varied assaults of administrators, politicians, public, and sometimes of other sections of the medical profession. At the same time the bird reserves its right, at any time, to be synchronously both revolutionary and stationary, without prejudice.

<sup>†</sup> Ref. Document HIDE Alpha minus/399-398 BC: Extract from the report of the Deputy Treasurer, Socrates "Crito, we owe a cock to Aesculapius....".

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#### COST

In the materials displayed the makers will produce either design at cost prices less than £1 (and considerably less in quantities of the order of 300 or more are ordered). This would permit if sufficient stock were obtained of a sale price (including postage) of £1.00 - £1.50 when each tie sold would provide an appreciable contribution for the Dain Fund. A higher price would, of course, allow of a larger donation being made to charity from the sales. It is recommended that the price be £1.50 per single tie, and £1.25 each if three or more are bought simultaneously.

#### DISTRIBUTION

Should the Committee decide to adopt one or both designs, it would be for the Committee to decide who would be entitled to purchase and wear either or both. In this decision, it would be necessary to balance the desire that the insignia be reasonably exclusive whilst at the same time raising as much money as possible for charitable purposes. It is recommended that all past and present members (including observers) of the Committee should be eligible, and that the tie(s) should be available to past and present members of the staff of the Committee. It would, of course, be open to the Committee to award a tie or ties to other persons as a mark of respect or appreciation of service to the cause of general practice.

J G Ball  
B Holden  
D L Gullick



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Throughout this section the following abbreviations are used:-

Ann. Conf.	Annual Conference of Representatives of Local Medical (and Panel) Committees
ARM	Annual Representative Meeting
BMA	British Medical Association
BMJ	British Medical Journal
BMJ Supp	British Medical Journal Supplement
Doc.	Document
GMSC	General Medical Services Committee
GP	General Purposes
IAC	Insurance Act(s) Committee
NHS	National Health Service
RB	Representative Body
S/comm.	Sub-committee
Spec. Conf.	Special Conference of Representatives of Local Medical (and Panel) Committees
SRM	Special Representative Meeting

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